

To Receive Electronic Communication

Patient Name: _____ . Date of Birth _____ .

I agree that the dental practice may communicate with me electronically at the email address below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

I am responsible for providing the dental practice any updates to my email address.

I can withdraw my consent to electronic communications by calling 734-285-8600.

Email Address: (Please type a valid email in the box below)

_____ .

Patient/Guardian: _____ . Date: _____ .