Peter Hoffmann DMD PC

Patient Agreement to Receive Electronic Communications

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:
  814-726-3630

Email: _____@_____._____

Patient Signature:_____Date:_____

Staff Member Signature:_____Date:_____

Form effective 9/23/2013