Goodman
ENDODONTICS

Agreement 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: **(404) 885-1441**

Email Address (PLEASE PRINT CLEARLY):

_____@_____

Patient Signature: _____

Date: _____

999 Peachtree Street NE Suite 705 Atlanta GA 30309

T 404 885 1441 F 404 885 1410 Goodmanendo.com