Cocozzo Family Dentistry

4 Hemphill Place, Suite 151

Malta, N.Y. 12020

Agreement to Receive Electronic Communication

Patient Name: _____ Date of Birth: _____

(Initial below)

I _____ DO AGREE

I _____ DO NOT AGREE

That the dental practice may communicate with me electronically at the email address and/or mobile phone number listed below.

I am aware that there is some level of risk that third parties might be able to read uncrypted emails. I further agree that I am responsible for providing the dental practice any updates to my email address and/or mobile phone number.

My most preferred method of electronic communication:

(Initial below)

_____ Text Messaging

_____ Email

I would like to receive:

_____ Appointment Reminders/Recall Visits

_____ Information regarding insurance/billing

_____ Requests for patient satisfaction online reviews

I can withdraw my consent to electronic communications at any time by calling:

Cocozzo Family Dentistry / 518-899-5800 / Cocozzofamilydentistry@live.com

Patient Signature: _____ Date: _____