

Linkoff Dental Center
1445 Liberty Road
Eldersburg, Maryland 21784
410-795-2900

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 unencrypted 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:

_____ Text Message
_____ Email

I would like to receive:
_____ Appointment Reminders/Recall Visits
_____ Information regarding insurance/billing
_____ Requests for Patient Satisfaction Online Reviews

Email Address: _____

Cell Phone Number: _____

**I can withdraw my consent to electronic communications at any time by
calling:
Linkoff Dental Center
410-795-2900**

Patient Signature: _____
Date: _____