Agreement to Receive Electronic Communication

Patient Name:_____Date of Birth:_____

I agree that the dental practice of Dr. Amanda F. Leong D.D.S may communicate with me electronically via Text and/or 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:

(510) 523-7600 or (510) 865-6625

Email Address (PLEASE PRINT CLEARLY):

_____@_____

Patient Signature:_____

Date:_____