Kegler, Kegler, & Arend, DDS, PC

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.

(Initial below)

I ____AGREE

I ____DO NOT AGREE

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

Email Address (PLEASE PRINT CLEARLY):

_____@_____

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: **(319) 334-3342**

Patient Signature: _____

Date: ____/____/20_____