ADVANCED SEDATION & GENERAL DENTISTRY
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 the practice at **(207) 985-3576**

Email Address (PLEASE PRINT CLEARLY)

____ @ __________________________

Patient Signature

____ Date: ________________________

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Acknowledgement of Receipt of Notice of Privacy Practices

you may refuse to sign this acknowledgement

I was offered or I have received a copy of this office's Notice of Privacy Practices.

Print name ____

Signature ____________________________________ Date _________________

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

___ Individual refused to sign
___ Communications barriers prohibited obtaining the acknowledgment
___ An emergency situation prevented us from obtaining acknowledgement
___ Other (please specify)