OSBORNE
DENTISTRY

ELECTRONIC COMMUNICATIONS CONSENT

First Name:_____ Last Name: _____

PLEASE PROVIDE BOTH AN EMAIL ADDRESS AND CELL NUMBER TO HAVE ON FILE

Email Address (*required, print clearly*): _____

Texting Cell Phone Number (*required*): _____

PATIENT ACKNOWLEDGMENT AND AGREEMENT:
By signing below, I consent to Osborne Dentistry contacting me electronically using the cell phone and/or email address listed above for the purpose of appointment related details, such as scheduling/appointment reminders, billing, or post treatment surveys. I understand that during transmission of these messages, the information contained may pass through a public network and onto a personal electronic device and as such the transmission may not be secure or private. Osborne Dentistry is not liable for improper disclosure of confidential information caused by patient/parent/legal guardian or any third party. Osborne Dentistry requests that patients call to discuss any details involving private or time sensitive treatment matters. I agree to inform the practice if my email address or cell phone number changes. I understand the risks of electronic communication and acknowledge that I can cancel this consent at any time by contacting the office.

Patient Signature: _____ Date: _____

If you would NOT like to be contacted by email or text message you may opt out of one or both by initialing below. You may opt out later by following instructions contained within the correspondence. Additionally, if you change your mind, you may call us at 541-451-4300.

☐ I prefer to **OPT OUT OF EMAIL**. PLEASE INITIAL _____

☐ I prefer to **OPT OUT OF TEXT MESSAGING**. PLEASE INITIAL _____