Annapolis Center for Dental Health & Wellness
Vernon L. Sheen, D.M.D., P.A.

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:

410-266-1007 ______________________________________

Email Address (PLEASE PRINT CLEARLY):

____@__________________________

Patient Signature: ____

Date: ________________________

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