east cobb ORTHODONTICS

SMILES BY CAPPS & IACULLI

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:

[770-993-7118]

Email Address (PLEASE PRINT CLEARLY):

_____

Patient Signature/Guardian if under the age of 18:

_____

Date: _____