PEAK CITY
FAMILY DENTISTRY

Kelly F. Viau, D.D.S., P.A.

Patient Name: _____ Date of Birth:_____

I agree that Peak City Family Dentistry may communicate with me electronically at the email address below. I also agree that Peak City Family Dentistry may send emails, including xrays, to dental specialists on my behalf when treatment is deemed necessary.

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:

919-362-8797

Email Address (PLEASE PRINT CLEARLY):

_____@_____

Patient Signature:_____

Date:_____