



DENTAL ASSOCIATES OF WALPOLE

Family ◦ Specialty ◦ Care

EMAIL CONFIRMATION REQUEST FORM

Please read and fill out form completely

Today's Date: _____

Family Member who is **financially** responsible for your account:

First Name: _____

Last Name: _____

Email Address: _____@_____._____

If you would like appointment confirmations to be sent to other email addresses, please provide in the space below.

<u>Patient Name</u>	<u>Email Address</u>
<u>Patient Name</u>	<u>Email Address</u>
<u>Patient Name</u>	<u>Email Address</u>
<u>Patient Name</u>	<u>Email Address</u>

Please include your phone number so we can contact you if we need additional information.

Only the head of household or responsible party will be able to view financial information. Patients who are not responsible parties will be able to view appointment information, but not financials.