



PATIENT NAME: _____ DOB: _____

EMERGENCY CONTACT INFORMATION

In case of emergency, who should we contact? _____

Phone _____

Relationship to patient _____

Do you give our office permission to discuss your medical information with family members?

YES _____ **NO** _____ **SAME AS ABOVE** _____

If yes, and contact person is different from above, please provide their names and phone numbers below:

1) Name: _____

Phone: _____

Relationship to Patient: _____

2) Name: _____

Phone: _____

Relationship to Patient: _____

May we leave personal medical information on your answering machine at home?

YES _____ NO _____

May we mail or email medical information to you? YES _____ NO _____

Email Address: _____

Patient/Guardian Signature: _____ Date: _____