New Patient Confidential Information Referred to this office by: _____

Name_____ Date of Birth _____ Age _____

SSN _____ e-mail_____

Home # _____ Cell # _____ Work # _____

Address _____ City _____ State_____ Zip_____

Check One: [ ]Married [ ]Single [ ]Widowed [ ]Divorced [ ]Separated [ ] Child

Occupation _____ Job Description _____

Name of Emergency Contact _____

Address _____ Phone ( ) _____

If Patient is a minor, complete this section with parent/guardian information

Name_____ Date of Birth_____

Address_____ City _____ State _____ Zip_____

SSN _____ e-mail _____

Home # _____ Cell # _____ Work # _____

I authorize the following form of communication to be used for appointment reminders and understand that this will be applicable for all future appointments unless I fill out a written revocation.

_____ Phone Call

I authorize this number to receive reminder phone calls ( ) _____

_____ Text Message

I authorize this number to receive reminder text messages ( ) _____

_____ I hereby revoke my request to receive any future appointment reminders via phone call/text.

This office does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact carrier for pricing plans and details).

_____ _____

Patient/ Patient Representative Signature Date