

herein after referred to as "Provider"

## **Patient's General and Emergency Contact Information Sheet**

Please complete this form by indicating a check mark in each section that would be an acceptable manner in which our practice can contact you.

- In case of an emergency I authorize Provider to contact \_\_\_\_\_  
at (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_. My relationship to this contact is: \_\_\_\_\_

I wish to be contacted by Provider in the following manner (please check all areas that would be an acceptable manner for Provider can contact you):

- Please contact me on my home telephone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_
- Provider can leave their name and phone number only when they call.
  - Provider can leave a detailed message when they call.
- Please contact me on my cellular phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_
- Provider can leave their name and phone number only when they call.
  - Provider can leave a detailed message when they call.
- Please contact me at work: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_
- Provider can leave their name and phone number only when they call.
  - Provider can leave a detailed message when they call.
- Provider can mail or email me information such as appointment reminders, and future clinical sponsored programs.
- Provider can mail information to my home address.
  - Provider can mail information to my work address.
  - Provider cannot mail information to my home or work address, except statements of my account.
  - Provider may send me email messages such as appointment reminders at the following email address: \_\_\_\_\_. (Leave blank if you do not wish to be contacted via email.)
- I hereby give permission to Provider, to release medical information pertinent only to my current medical condition to: \_\_\_\_\_ relationship: \_\_\_\_\_

\_\_\_\_\_  
Patient's Name (Please Print)

\_\_\_\_\_  
Signature of Patient, Parent or Legal Guardian

\_\_\_\_\_  
Date