



PATIENT GENERAL CONSENT/FINANCIAL RESPONSIBILITY FORM

Patient Name: _____ Date of Birth: _____

Appointment Time: _____ Arrival Time: _____

Patient's Height: _____ Patient's Weight: _____ (required because of Health Care Reform Act)

Primary Care Physician Name: _____ PCP Phone: _____

If you prefer us to send billing statements and/or other correspondence to an address other than your home address, please print that address below:

Street Address _____ City/State/Zip _____

Please list below any family member or other persons we may inform about your medical condition and your diagnosis. If for emergency only, please mark as such.

Name: _____ Relationship _____ Phone: _____

Name: _____ Relationship _____ Phone: _____

Name: _____ Relationship _____ Phone: _____

Can we leave confidential messages such as appointment reminders on your home phone voicemail? Or, if you give us another number to call, can we do the same on that phone number? Yes _____ No _____

We are now making greater use of e-mail to communicate with our patients. To help us provide the most prompt service possible, please enter your current e-mail address below:

Grid for e-mail address input

NOTE: All patient information is kept strictly confidential. Your address is NEVER shared.

If we have something important to tell you or we can't contact you otherwise, would you like a text message sent to your cell phone? Yes _____ No _____ Cell Number: _____

Patient Signature (Parent/Guardian Signature if Patient is a Minor) _____ Date _____

