



Patient Name: _____

Birthdate: _____

Due to HIPPA compliance, please list the family members or other persons, if any, whom we may inform about you or your child's treatment, appointment and financial information:

Please list the telephone number, email address and cellular phone number (for texting) that you would like to receive appointment reminders on:

Telephone number: _____

Email address: _____

Cellular phone number: _____

Cellular Carrier (required for text reminders): _____

Signature of Parent or Legal Guardian _____

Relationship to Patient: _____

Signature of Patient (if over the age of 18) _____

Date: _____