PATIENT CONTACT INFORMATION FORM

Patient Name: _____
Date of Birth: _____
Preferred Name (if different): _____

CONTACT INFORMATION

Primary Phone Number: _____ ☐ Cell ☐ Home ☐ Work
Secondary Phone Number: _____ ☐ Cell ☐ Home ☐ Work
Email Address: _____
(For appointment reminders and clinic communication)

MAILING ADDRESS

Street Address: _____
City, State, ZIP: _____

EMERGENCY CONTACT

Name: _____
Relationship to Patient: _____
Phone Number: _____

PREFERRED CONTACT METHOD (Check all that apply)

☐ Phone Call ☐ Text Message ☐ Email ☐ Patient Portal

CONSENT FOR COMMUNICATION

I authorize Westside Pediatric Clinic, P.C. to contact me using the information provided above for appointment scheduling, reminders, billing, and other healthcare-related matters. I understand that I can update my contact preferences at any time by notifying the clinic.

Signature of Patient (18+): _____ **Date:** _____