Beautiful Minds Medical, Inc

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 Beautiful Minds Medical, Inc. can contact you.

☐ In case of an emergency I authorize Beautiful Minds Medical, Inc. to contact _____

at (_____) _____-_____. My relationship to this contact is: _____

I wish to be contacted by Beautiful Minds Medical, Inc in the following manner (please check all areas that would be an acceptable manner for Beautiful Minds Medical, Inc. can contact you):

☐ Please contact me on my home telephone: (_____)_____-_____

- ☐ Beautiful Minds Medical, Inc can leave their name and phone number only when they call.
- ☐ Beautiful Minds Medical, Inc can leave a detailed message when they call.

☐ Please contact me on my cellular phone: (_____)_____-_____

- ☐ Beautiful Minds Medical, Inc can leave their name and phone number only when they call.
- ☐ Beautiful Minds Medical, Inc can leave a detailed message when they call.

☐ Please contact me at work: (_____) _____-_____

- ☐ Beautiful Minds Medical, Inc can leave their name and phone number only when they call.
- ☐ Beautiful Minds Medical, Inc can leave a detailed message when they call.

☐ Beautiful Minds Medical, Inc can mail or email me information such as appointment reminders, and future clinical sponsored programs.

- ☐ Beautiful Minds Medical, Inc can mail information to my home address.
- ☐ Beautiful Minds Medical, Inc can mail information to my work address.
- ☐ Beautiful Minds Medical, Inc cannot mail information to my home or work address, except statements of my account.
- ☐ Beautiful Minds Medical, Inc. 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 herby give permission to Beautiful Minds Medical, Inc, 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