

Patient's Contact Information Sheet

Please complete the below and indicate with a check mark what would be an acceptable manner for us to contact you:

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

at (_____) _____ - _____ relationship: _____.

2) I wish to be contacted in the following manner (please check all areas that apply for you):

Home telephone: (_____) _____ - _____. If you get my voice mail, please:

Leave your name and phone number only, no detailed message.

Leave a detailed message.

Mobile: (_____) _____ - _____. If you get my voice mail, please:

Leave your name and phone number only, no detailed message.

Leave a detailed message.

Work phone: (_____) _____ - _____. If you get my voice mail, please:

Leave your name and phone number only, no detailed message.

Leave a detailed message.

Mail or e-mail me information such as appointment reminders, and future clinical sponsored programs to my:

E-mail: _____ @ _____

Mailing address: _____

Do not mail information to my home or work address, except statements of my account.

I hereby 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