# PATIENT CONTACT FORM

**Patient** _____ **DOB** _____

I authorize CMC to register my email address so that I may voluntarily have electronic access(portal) to view and manage my child's information, medical records, request prescriptions, view past appts, eStatements, etc. Y N (circle one)

### Mother/Legal Guardian

Please mark yes or no on which of the numbers we have permission to contact you and/or leave a message.

Y N Home _____
Y N Cell Phone _____ Y N Work _____

May we email and/or text your appointment reminders? Y N

Email Address: _____

### Father/Legal Guardian

Please mark yes or no on which of the numbers we have permission to contact and/or leave a message.

Y N Home _____
Y N Cell Phone _____ Y N Work _____

May we email and/or text your appointment reminders? Y N

Email Address: _____

Do you have any health information that you would like to keep confidential from any person(s)? Y N
If so, please describe: _

---

May we fax your child(ren)'s shot record to his/her school if you verbally request us to do so? Y N
Name of school(s) _____

_____
Parent/Guardian Signature Date

_____ _____
Printed Name Relationship to Patient

**<u>For Office Use Only -</u> We attempted to obtain the above information, but the information could not be obtained because:**

**( ) Individual refused to sign**
**( ) Communication barriers prohibited obtaining the information**
**( ) An emergency prevented us from obtaining the information**
**( ) Other (Please Specify) _____**

_____ _____ _____
Witness Signature Title Date