Patient Information Form

Please Note: This is a confidential record of your medical history and will be kept in this office.

Name	M.I.	Last Name	
Address	City	State	Zip
Phone	Second Phone		
Date of Birth	Age	Male □	Female □
Employer	Occupation		
Married □ Single □ Divorced □	Name of Spouse		
Emergency Contact	Phone Number		
E-Mail	Referred By: Friend □ Relative □ Insurance □ Other □		

Authorization to be Contacted via Text and Email

Rachelle Lambert offered reminders about your appointment via text and email. She also sends out once monthly newsletters. By signing below you authorize contact to be made by text and email.

Patient Name (Print) Patient Signature Date

24 Hour Cancellation Policy

Rachelle Lambert takes pride in the quality of care she offers her patients. In order to do this, she has a strict cancellation/rescheduling policy. Rachelle requires a 24-hour cancellation or rescheduling notice prior to your appointment time. If sufficient time is not given, half of the fee will be charged.

Patient Name (Print) Patient Signature Date