EMR Required Information/Appointment Policy

Name _____

Home Phone Number _____

Cell Phone Number _____

Email _____

Preferred Pharmacy _____

Pharmacy Address _____

Pharmacy Phone Number _____

Race* _____

Ethnicity* _____

Religion*_____

Preferred Language* _____

* We are legally required to report this information. Please inform us if there are any changes to the above information.

Appointment Policy

- Missed Office Appointment - If you wish to cancel your appointment, please inform our office at least 24 hours in advance. Otherwise, you will be responsible for a $50 cancellation charge (not billable to insurance).
- Missed Procedure Appointment - If you wish to cancel your appointment, please inform our office at least 72 hours in advance. Otherwise, you will be responsible for a $150 cancellation charge (not billable to insurance).

By signing this form, I confirm that all information given above is correct and I understand and agree with the appointment policy.

Signature _____ Date _____