# Bucks Rehabilitation Specialists

## How would you like to be contacted?

### Patient Contact Information

**If you chose more than one way of being contacted; please rank – 1 being most preferred.**

| **How can we send you appointment information?** | **If necessary, how can we send medical information?** |
|---|---|
| ❑ Voice Mail (Give Numbers)<br>❑ Home _____<br>❑ Cell _____<br>❑ Office _____<br>❑ Text ****_____<br>❑ E-Mail _____<br>❑ Fax _____<br>❑ Postal Mail<br>Address: _____<br>_____ | ❑ Voice Mail (Give Numbers)<br>❑ Home _____<br>❑ Cell _____<br>❑ Office _____<br>❑ E-Mail _____<br>❑ Fax _____<br>❑ Postal Mail<br>Address: _____<br>_____ |

### Non-Patient Contact Information

| **I authorize appointment information to be given to:** | **I authorize medical information to be given to:** |
|---|---|
| Name & Relation: _____<br>_____<br>❑ Voice Mail (Give Numbers)<br>❑ Home _____<br>❑ Cell _____<br>❑ Office _____<br>❑ Text ****_____<br>❑ E-Mail _____<br>❑ Fax _____<br>❑ Postal Mail<br>Address: _____<br>_____ | Name & Relation: _____<br>_____<br>❑ Voice Mail (Give Numbers)<br>❑ Home _____<br>❑ Cell _____<br>❑ Office _____<br>❑ E-Mail _____<br>❑ Fax _____<br>❑ Postal Mail<br>Address: _____<br>_____ |

Patient Name: _____ ****NEED NAME CELL PHONE CARRIER (ie Sprint,etc.)

Patient Signature: _____ Phone Carrier _____

Date: _____ DOB: _____ _____