BRAIN
PERFORMANCE CENTER

Patient Contact Information

Last Name:_____ First Name:_____

D.O.B.: _____

Cell Phone: _____ Home Phone: _____

Work Phone:_____

E-mail Address: _____

Address: _____ City: _____

State: _____ ZIP: _____

If patient is a minor please list guardian's name(s):

Name (s):_____

Consent to Receive Text Messages or E-mails for Appointment Reminders:

Patients in our practice may be contacted via email or text messaging to remind them of an appointment.

If you would like a reminder please circle one: TEXT MESSAGE E-MAIL

I consent to receive text /e-mail reminder messages from The Brain Performance Center at my cell phone (and any number forwarded or transferred to that number) or e-mail address to receive appointment reminders. I understand that this request to receive text/e-mail messages will apply to all future appointment reminders unless I request a change in writing. The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan.

Signature: Date: