PATIENT INFORMATION

Nancy L. Sack, Ph.D.
(334) 590-8492

Patient Name _____ Today's Date _____

Mailing Address _____ SSN _____

City _____ State _____ Zip _____ Date of Birth _____

Living Address (if different) _____

Permanent Address (if different) _____

Home Phone _____ Work Phone _____ Cell Phone _____

I Give My Consent to be Contacted At ☐ Home ☐ Work ☐ Cell Limitations _____

I Give My Consent to Leave Voice Messages At ☐ Home ☐ Work ☐ Cell Limitations _____

I Give My Consent to Leave Text Messages On Cell ◉ Yes ○ No Limitations _____

Email Address _____ I Give Consent to Use Email ◉ Yes ○ No Limitations _____

Your Employer _____ Occupation _____

Work Address _____

Spouse/Partner's Name _____ Cell Phone _____ Work Phone _____

Spouse/Partner's Occupation _____

Psychiatrist _____ Phone _____

Primary Medical Care Provider (M.D., D.O., NP) _____ Phone _____

Hospital Closest to Your Home _____ Phone _____

Police In Your Area _____ Phone _____

Whom May Dr. Sack Contact in Case of Emergency? _____ Phone _____ Relationship _____
(Required)

Nearest Relative Not Living With You _____ Phone _____ Relationship _____

How Did You Hear About Dr. Sack? _____

MY SIGNATURE BELOW:

ACKNOWLEDGES: - accuracy of the above information and financial responsibility to pay

CONSENTS: - to evaluation and/or treatment of me

_____
PRINTED NAME OF PATIENT

_____ _____
SIGNATURE OF PATIENT DATE