Matthew Zimmerman, M.D.
105 East 15 Street, #1
New York, NY 10003
(212) 658-0639

Patient Information Form

NAME: _____ DATE OF BIRTH: _____

CELLPHONE: _____ OTHER PHONE: _____

E-MAIL ADDRESS: _____

Mark all that apply: ☐ I do not text message. ☐ I do not check/respond to e-mail regularly.

HOME ADDRESS: _____

_____

PREFERRED PHARMACY INFORMATION: _____

_____

CREDIT CARD NUMBER: _____

NAME ON CARD (*if different from above*): _____

EXPIRATION DATE: _____ SECURITY CODE: _____ ADDRESS ON CARD (*if different from above*):

_____

EMERGENCY CONTACT: _____ RELATION: _____

CELLPHONE: _____ OTHER PHONE: _____

Initial the statements below after you have read them. Sign at the bottom to indicate that you agree.

☐ I verify that the information above is accurate as of the date below. I will inform Dr. Zimmerman of any changes.

☐ I am aware that I will be billed my normal fee for missed sessions if I do not cancel 72 hours or more prior to the scheduled start time. (There will be no fee if the time is filled.)

☐ I authorize Dr. Zimmerman to bill my credit card on file if my payment is not received by the due date.

SIGNATURE: _____ **DATE**: _____