



Patient Demographics, Contacts, and Communication Permissions

Orville R. Weyrich, Jr, PhD, NMD, BCN, ABAAHF

Patient Legal Name: (First) _____ (Middle) _____ (Last) _____ (Suffix) _____

Preferred Name: _____ Date of Birth: ____/____/____

Other Names Appearing in Medical Records: _____

Mailing Address Street: _____ City _____ State ____ Zip _____

Physical Residence Address, if different: _____

Usual state of residence/domicile: _____

Patient Contact Preferences (provide contact info to be used):

- ☐ Secure email _____ @ _____
- ☐ Ordinary unencrypted email _____ @ _____
- ☐ Cell Phone (_____) _____ - _____
- ☐ Other Phone (_____) _____ - _____ ext _____ type: _____
- ☐ Other Phone (_____) _____ - _____ ext _____ type: _____
- ☐ Text/SMS (_____) _____ - _____
- ☐ Voicemail (_____) _____ - _____ ext _____ type: _____
- ☐ Fax (_____) _____ - _____ Attn: _____
- ☐ Postal mail _____
- ☐ Zoom/FaceTime/other video (specify) _____
- ☐ Patient portal — not currently available for Dr. Weyrich
- ☐ Other: _____

Depending on technical, privacy, security, legal, clinical, and scheduling constraints, not all listed methods may be available for every communication or service. A video-platform selection indicates preference only and does not guarantee availability.

Message permissions:

- ☐ Name and callback number only
- ☐ Scheduling/billing information only
- ☐ Detailed health-related message allowed
- ☐ Do not leave voicemail
- ☐ Other restrictions: _____

Contacts and Authorized Persons:

Listing a person on this form authorizes only the role(s) and activities checked for that person, subject to any restrictions stated. Roles and activities are non-exclusive and may be fulfilled by multiple named individuals. This form does not list, revoke, or limit other persons who may have authority under separate legal documents, releases, authorizations, or applicable law.

Person: _____ **Relationship to patient:** _____

Role: ☐ Legal representative / health-care decision-maker (authority as stated in legal documentation)

Documentation of legal authority: ☐ Requested ☐ On file _____

☐ Other support person – authorized herein to do the following:

☐ Emergency contact

☐ Attend appointments

☐ Help complete forms and gather records

☐ Provide information to the practice

☐ Receive scheduling or administrative information

☐ Discuss symptoms, records, labs, medications, recommendations, or care coordination

☐ Receive copies of reports or records

☐ Communicate with the practice about payment or logistics

☐ Other _____

Restrictions: _____

Contact information: _____

[Attach additional entries as needed using form 00-Demographics-Add]

This form updates the patient's demographics, contact information, communication preferences, message permissions, and listed contacts. It does not revoke or replace other written consents, authorizations, releases, legal decision-making documents, service agreements, payment agreements, or clinical information unless expressly stated in writing.

Communication permissions may be changed or revoked by written notice, except to the extent that the practice has already acted in reliance on the prior permission.

Patient / Representative Signature

Patient Legal Name (printed):

(First) _____ (Middle) _____ (Last) _____ (Suffix) _____

Date of Birth: ____/____/____

Legal guardian or authorized representative, if applicable (printed):

(First) _____ (Middle) _____ (Last) _____ (Suffix) _____

Relationship _____ Authority to sign _____

Signer is: ☐ Patient ☐ Legal guardian ☐ Authorized representative

Signature _____ Date ____/____/____