KKAUR MD

Patient Emergency Contact Form

_____ _____

Printed Patient Name (Last Name First) Date of Birth

_____

Mailing Address

_____ _____

City and State Zip Code and Country

(_____)_____ (_____)_____

Primary Phone Number (Mobile / Home) Secondary Phone Number(Mobile / Home)

_____

Email Address

Emergency Contact Information

_____ _____

Emergency Contact Name Relationship to Patient

_____

Mailing Address

_____ _____

City and State Zip Code and Country

(_____)_____ (_____)_____

Primary Phone Number (Mobile / Home) Secondary Phone Number(Mobile / Home)

_____

Email Address

[ ] I give **KKaur MD** consent to contact the aforementioned individual in the event of a medical emergency & disclose any and all necessary PHI to him/her/them.

By signing this document, I understand & agree that this consent and confirmation is valid until I provide written Notice to the Practice of otherwise.

Signature: _____ Date _____

Printed Name (if Not Patient): _____

Relationship to Patient: _____