HealthWise
Family Practice

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Information Update and Consent Form

*Please print clearly

Patient Name ____

Date of birth ____

Address ____

Email address ____

Home phone ____

Work phone ____

Cell phone ____

Pharmacy name and location _______________________________

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I give consent for any representative of HealthWise Family Practice to leave personal messages on my:

___ Home phone

___ Work phone

___ Cell phone

I also consent to receiving email and/or text message reminders from HealthWise Family Practice.

I understand that I will be charged for a missed appointment or one cancelled within 12 hours of the appointment time. I understand that this fee must be paid prior to scheduling any further appointments.

Signed ________________________

Date ________________________