Lakeview TMS Center

LAKEVIEW TMS CENTER

Patient Name: _____ Appt. Date: _____

Date of Birth: _____ Age: _____ Sex: _____

Marital Status: Single _____ Married _____ Widowed _____ Separated _____ Divorced _____

Address: _____ City _____ Zip _____

*Cell Phone: _____ *Alt Phone: _____

Email: _____

DL #: _____

Employer: _____ Occupation: _____

Work Address: _____ City: _____ Zip: _____

Work Phone: _____

Referred By: _____

Primary Care Physician: _____

Responsible Party Info:

Responsible Party: _____

Relationship to Patient: _____

DL #: _____ Date of Birth: _____

Address: _____ City _____ Zip _____

*Home Phone: _____ *Cell Phone: _____

Employer: _____ Occupation: _____

Work Address: _____ City: _____ Zip: _____

Work Phone: _____

Insurance:

Do you have medical insurance? Yes _____ No _____ PPO _____ HMO _____

Primary Insurance: _____

Emergency Contact: _____

Relationship to Patient _____

Address: _____ City _____ Zip _____

*Home Phone: _____ *Cell Phone: _____

Work Phone: _____ Email: _____

Preferred Pharmacy: (Name, Number, Location)

_____

_____

**We have a 24- hour cancellation/no show policy. You will be charged at the full appointment fee for missed appointments. Call if you have any questions. **

* *Please send copy of your drivers license and health insurance card* *

Lakeview TMS Center 2249 Ridge Road, Rockwall, TX 75087
469-402-7867 or fax 469-402-7868