

# TOUCHPOINT

PEDIATRICS, P.A.

## Primary Contact Preferences

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Sibling(s) Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Sibling(s) Name: \_\_\_\_\_ DOB: \_\_\_\_\_

### What is your preferred method of contact?

*(Please choose one method for each category)*

**General Notices, Appointments, Recalls and Reminders** *(Inclement Weather, Office Announcements etc.)*

Home Email

or

Text to Cell

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I do not wish to be contacted electronically. Please contact me at the following number for all office/patient related issues.

Telephone: \_\_\_\_\_

**Our system requires (1) primary email address and (1) primary cell phone number to be listed per family**

Primary Name: \_\_\_\_\_

Primary Cell Phone: \_\_\_\_\_

Primary Email Address: \_\_\_\_\_

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I approve the above method of contact from Touchpoint Pediatrics.

\_\_\_\_\_  
*Printed Primary Parent/Guardian Name*

\_\_\_\_\_  
*Signature Primary Parent/Guardian*

\_\_\_\_\_  
*Date*