



**Pam Chin-Lai MS, RD, LD**  
Nutrition Consultant

## PATIENT INFORMATION FORM

Date: \_\_\_\_\_

Client's name: \_\_\_\_\_

Client's address: \_\_\_\_\_

Home Phone: \_\_\_\_\_

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

Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

*If under 18 years of age*

Parent's name: \_\_\_\_\_

Parent's address: \_\_\_\_\_

Home phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_

Email: \_\_\_\_\_

Referred by:  
\_\_\_\_\_

I understand that appointment times are reserved exclusively for me therefore 24 hours advance notice is required for cancellations, otherwise full payment is due.

Signature: \_\_\_\_\_

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