Sonya Vieira, M.D.
352 7th Avenue, Suite 1005
New York, NY 10001
(646) 265-9484

Date: _____

Patient Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Preferred Phone: _____ Cell Home Work

Secondary Phone: _____ Cell Home Work

Email (only used with your permission): _____

Date of Birth: _____ Age: _____ Gender: _____

Emergency Contact Name: _____

Relationship: _____ Phone: _____

Parent or Guardian Information

Name: _____

Preferred Phone: _____ Cell Home Work

Secondary Phone: _____ Cell Home Work

Email (only used with your permission): _____

Authorization: I hereby authorize Dr. Sonya Vieira to provide psychiatric and psychotherapeutic care, administer tests, medications, and treatments. I understand that I am financially responsible for all charges whether or not covered by insurance.

_____ _____
Signature of Parent or Guardian Date

Consent to Communication via Email: I hereby consent to have Dr. Sonya Vieira communicate with me via email. I understand that email is not a confidential method of communication. I understand that in an urgent or emergent situation I should call my provider or go to the Emergency Room and not rely on email.

_____ _____
Signature of Parent or Guardian Date