

PATIENT QUESTIONNAIRE

1. Please list the family members or other persons if any whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

Name

Name

Name

2. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

Name

Phone

Name

Phone

3. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home.

Address

City

State

Zip Code

4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL" YES NO
5. Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other health care information if other than your home phone number:

Phone

6. Can confidential messages (i.e. appointment reminders) be left on your telephone answering machine or voicemail? YES NO

"I am fully aware that a cellphone is not a secure and private line"

Patient Name

(guardian if under 18 years of age)

Patient/guardian Signature

Date