

PATIENT QUESTIONNAIRE

- Please list 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):

- 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 #: _____

- 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.

- Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL":

Yes: _____ No: _____

- 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: _____

***I am fully aware that a cell phone is not a secure and private line.**

- Can confidential messages (i.e., appointments reminders/testing results) be left on your telephone answering machine or voicemail?

Yes: _____ No: _____

PATIENT NAME: _____

PATIENT SIGNATURE

DATE