PATIENT QUESTIONNAIRE

PATIENT NAME ____

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 ____ Phone Number ____________________
   Name ____ Phone Number ____________________

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 Number _____________________
   Name ____ Phone Number _____________________

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

   ____
   ____

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: ______________________

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

6. Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voicemail?

   YES ________ NO _________

________________________________ ____________________

PATIENT/GUARDIAN SIGNATURE **DATE**
(if patient under 18 years old)