

Patient Questionnaire

Please list the family members or significant others, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and post op operation).

Name: _____ Relationship: _____ PH#: _____

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

Name: _____ Relationship: _____ PH#: _____

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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: _____

EMAIL ADDRESS: _____

Please print the telephone number where you want to receive calls about your appointments, lab & x-ray results, or other health care information if other than your home phone number _____.

Can confidential messages (i.e. appointment reminders) be left on you telephone answering machine or voice mail? Yes _____ No _____

Please indicate which pharmacy we may speak to regarding any prescriptions, which may be prescribed or refilled. _____ ph# _____

If in the course of your treatment, you request supplies from a company which request information or a home health agency is prescribed, may we provide them with the necessary information needed for your treatment?

Yes _____ No _____

Patient Name: _____

Patient Signature

Date

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