PATIENT QUESTIONAIRE

"The Health Insurance Portability and Accountability Act "(HIPAA)

*Please print the telephone numbers and e-mail address, if any, **where you want to receive calls or information** about your appointments, labs, or other health care issues that would come directly from the physician or staff members: **If patient is a minor, please complete below information with the parent/guardians information..***

	O.K. TO CALL Yes	O.K. TO CALL No	Leave Message if no answer Yes	Leave Message if no answer No
Home Phone:______________________	☐	☐	☐	☐
Work Phone:______________________	☐	☐	☐	☐
Cell Phone:______________________	☐	☐	☐	☐

Email___________________________@_________________________________

Emergency Contact Person _________________________________Phone # __________________________

Parent/Guardian Name (of above information):__________________________

*2) **If you do not have** an answering machine, voicemail or home e-mail address, may we leave confidential messages at your place of employment to return our call?* ***Yes*** † ***No*** †

WE CANNOT RELEASE INFORMATION TO ANYONE UNLESS THEY ARE LISTED BELOW:

*3) Please list **family members or other persons**, whom we may talk to about your medical condition and/or diagnosis:*

Name ______________________________________Relationship______________________________

Name______________________________________Relationship______________________________

Name______________________________________Relationship______________________________

4) If different from your home address, please print the address of where you would like all correspondence from our office to be sent.

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The information on this questionnaire is good until updated by the patient and/or a new form is completed.
I have received the notice of Privacy Practices and have been provided an opportunity to review it.

Patient Name:_____________________________________ DOB:__________________________

Signature:____DATED:_________________________