

PATIENT PRIVACY AND CONTACT INFORMATION

Patient Name _____ Date of Birth _____

Parent/Guardian Name _____
(if patient is a minor or otherwise applicable)

1. Notice of Health Information has been read and/or received. Please sign below for Privacy Policy.

Patient Date Parent/Guardian (if applicable) Date

2. How may we contact you?

a. Home: ___ Yes ___ No Phone Number _____
May we leave a message? ___ Yes ___ No
Please check those that apply: ___ Voicemail/Answering Machine ___ Family Member

b. Cell: ___ Yes ___ No Phone Number _____
May we leave a message? ___ Yes ___ No
Please check those that apply: ___ Voicemail/Answering Machine ___ Family Member

c. Work: ___ Yes ___ No Phone Number _____
May we leave a message? ___ Yes ___ No
Please check those that apply: ___ Voicemail/Answering Machine ___ Family Member

d. Email: ___ Yes ___ No Email address _____

If you have specific instructions for us to note when leaving a message, please indicate below. We are required to keep all information confidential unless given specific instruction by the patient.

Initial _____ Date _____