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CONFIDENTIALITY QUESTIONNAIRE

1. 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 HEALTH CARE OPTIONS).

NAME_____PH_____

NAME_____PH_____

2. PLEASE LIST THE FAMILY MEMBERS OR SIGNIFICANT OTHERS, IF ANY, WHOM WE MAY INFORM ABOUT YOUR MEDICAL CONDITION ONLY IN AN EMERGENCY.

NAME_____PH_____

NAME_____PH_____

3. PLEASE PRINT THE ADDRESS WHERE YOU WOULD LIKE YOUR BILLING STATEMENTS AND/OR CORRESPONDENCE FROM OUR OFFICE TO BE SENT IF OTHER THAN YOUR HOME.

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4. PLEASE INDICATE IF YOU WANT ALL CORRESPONDENCE FROM OUR OFFICE SENT IN A SEALED ENVELOPE AND MARKED "CONFIDENTIAL". YES_____NO_____

5. PLEASE PRINT THE TELEPHONE NUMBER WHERE YOU WANT TO RECEIVE CALLS ABOUT YOUR APPOINTMENTS, LAB, XRAY RESULTS OR OTHER HEALTH CARE INFORMATION IF OTHER THAN YOUR HOME PHONE NUMBER.

PHONE NUMBER_____

6. MAY WE LEAVE A MESSAGE ON YOUR ANSWERING MACHINE REGARDING YOUR RESULTS OR HEALTH CARE INFORMATION? YES_____NO_____

7. WOULD YOU LIKE TO BE REMINDED OF YOUR APPOINTMENT? IF NO ANSWER, WE WILL LEAVE A MESSAGE ON YOUR ANSWERING MACHINE OR VOICE MAIL.
YES_____NO_____

8. I AM FULLY AWARE THAT A CELL PHONE IS NOT A SECURE AND PRIVATE LINE.
YES_____NO_____

PATIENT NAME _____(IF UNDER 18 YEARS GUARDIAN SIGNATURE)

PATIENT / GUARDIAN SIGNATURE _____DATE_____
POWER OF ATTORNEY NEED TO SHOW LEGAL DOCUMENTATION