

HIPAA COMPLIANCE
PATIENT QUESTIONNAIRE

- I. Please list the family members or other persons, if any, whom we may inform about your general condition and your diagnosis (including treatment, appointments, payment, and health care operations).

- II. Please list the family members or significant others, if any, that we may inform about your medical condition **ONLY IN AN EMERGENCY**.

Name _____ Phone Number _____
Name _____ Phone Number _____

- III. 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.

Address _____
City _____ State _____ Zip _____

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

Home Phone Number _____
Alternate Number _____
This phone number is: Cell _____ Work _____

- IV. Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voice mail?

Yes _____ No _____

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

PATIENT NAME _____ (guardian if under 18 years old)

Patient/Guardian Signature

Date