

Alternative Medicine Family Care Center

PATIENT QUESTIONNAIRE

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

- II. Please list the family members or significant others, if any, whom 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.

- IV. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL":

YES _____ NO _____

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

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

YES _____ NO _____

PATIENT NAME _____ (guardian if under 18 years)

PATIENT/GUARDIAN SIGNATURE

DATE