CLIENT CONTACT INFORMATION

Please list the family members or other persons, if any, whom we may inform about your health condition and your treatment.

____

____

Please list the family members or other persons, if any, whom we may inform about your health condition ONLY IN AN EMERGENCY.

Name ____________________________________ Phone ___________________________

Name ____________________________________ Phone ___________________________

Please print the address of where you would like any correspondence from our office to be sent ***if other than your home.***

____

____

Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL". _____ YES _____ NO

Please print the telephone number where you want to receive calls about your appointments or other health care information ***if other than your home phone number.***

____

Can we leave confidential messages (i.e. appointment reminders) on your telephone answering machine or voicemail? _____ YES _____ NO

PATIENT NAME (guardian if under 18 years) _____________________________________
(Please print)

PATIENT / GUARDIAN SIGNATURE ____

DATE _________________________________