

AUTUMN ROAD FAMILY PRACTICE, P.A.

PATIENT QUESTIONNAIRE

1. 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 operations):
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2. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

Name: _____ Phone: _____

Name: _____ Phone: _____

3. Please print the address of where you would like our 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 marked "CONFIDENTIAL":

Yes _____ No _____

5. 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:
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Please understand that a cell phone is not a secure and private line.

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

Yes _____ No _____

7. I acknowledge receipt of Autumn Road Family Practice Privacy Notice.

Please initial _____

PATIENT NAME _____ (GUARDIAN IF UNDER 18 YEARS OF AGE)

PATIENT/GUARDIAN SIGNATURE

DATE

This notice will remain in effect until such time our office is notified in writing by the patient of any changes.