Patient HIPAA Questionnaire

- Please print the telephone number where you want to receive calls about your appointments, lab, and x-ray results, or other health care information:

  ☎ (   ) ____________________________

  - Confidential voicemail can be left on this number: ☐ yes ☐ no
  - Confidential text message may be left at this number: ☐ yes ☐ no

- Please provide an e-mail that we can use to communicate with you, and register you for our secure online patient Portal:

  ____

  - Confidential emails may be sent to this provided email: ☐ yes ☐ no

  ☐ I understand that email is not a secure method of communication (***please initial***)

- 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):*

Name:		**Phone:**	
Name:		**Phone:**	
Name:		**Phone:**	

- 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:**	
Name:		**Phone:**	

- Where you would like billing statements and/or correspondence from our office to be sent?

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- Please indicate if you want all correspondence from our office sent in a sealed envelope marked **"CONFIDENTIAL"**: ☐ yes ☐ no

PATIENT NAME: ____ **DATE:** __________________

PATIENT/GUARDIAN SIGNATURE:

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