1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis

Name: _________________________________________________ Relationship: __________________________
Name: _________________________________________________ Relationship: __________________________

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

Name: __________________________________ Relationship: ____________ Phone Number: _______________
Name: __________________________________ Relationship: ____________ Phone Number: _______________

3. 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.

___________________________________________________________________________________________________________________

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: ___________________________

“I am fully aware 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 (If no, you will not receive an appointment reminder.)

7. Would you like to participate in the activation of FollowMy Health? ☐ Yes ☐ No

Using FollowMyHealth, you can:

● Communicate with your care team
● Access your test results
● View your recent clinic visits
● Request Prescription Renewals
● And more…..

To join please provide your email where your activation code will be sent: ________________________________________

8. I have been given a copy of my Patient Rights and Responsibilities. ☐ YES ☐ NO

9. I have been given a copy of the Joint Notice of Privacy Practices. ☐ YES ☐ NO

10. Advance Directives: Please check appropriate box.

Health Care Power of Attorney   ☐ NO
                                        ☐ NO
Living Will   ☐ NO
                                        ☐ NO

ou supplied us with a copy

Harnett Health
PO Box 1706 Dunn, NC 28335
Physician Office Practices
Patient Questionnaire