Physician Office Practices - 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.

   Name: ______________________  Relationship: __________________  Phone Number: __________________

   Name: ______________________  Relationship: __________________  Phone Number: __________________

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.

    Do you have a Health Care Power of Attorney?  □ YES  □ NO

    Living Will?  □ YES  □ NO

    Have you supplied us with a copy?  □ YES  □ NO

Patient/Legal Representative Signature: ___________________________ Date: __________  Time: __________

Print Name: ___________________________ Relationship to Patient: ___________________________

Witness Signature: ___________________________ Date: __________  Time: __________

Print Name: ___________________________