

**Patient Privacy Questionnaire – Southlake Neurology and Neurophysiology Clinic, PLLC**

Name of patient: Last: \_\_\_\_\_ First: \_\_\_\_\_

Write the names of family members and other persons, if any, whom we may inform about your medical condition and your diagnosis (including treatment, payment, and healthcare operations).

Member 1 \_\_\_\_\_ Member 2 \_\_\_\_\_  
Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

**In case of emergency**, write the names of family members and other persons, if any, whom we may inform about your medical condition

Member 1 \_\_\_\_\_ Member 2 \_\_\_\_\_  
Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you have an alternate address other than your home where you would like your billing statements and other correspondence from our office sent? If yes then indicate below:

Address line 1 \_\_\_\_\_ Address line 2 \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Do you have any other instructions regarding your correspondence? If yes please state:

Write the telephone numbers where we may call. If you don't want to be called somewhere, do not list the number. Cell phones, voicemail, and answering machines are not completely private.

Home phone ( )- - Yes No

Can we leave a message on the answering machine?  Yes  No

Can we leave a message with a person who answers your home phone?  Yes  No

Cell phone ( )- - Yes No

Can we leave a message on the voice mail?  Yes  No

Work phone ( )- - Yes No

Can we leave a message on the voice mail?  Yes  No

Patient's name (or guardian) printed \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Original signature required