PATIENT CONTACT / CONFIDENTIALITY FORM

1. Can we leave messages with anyone besides you? If so, whom:

_____

_____

2. Can we share you medical record with anyone besides you? If so, whom:
   Example: spouse, son, daughter; (Please list first name, last name, and relationship of each person)

_____

_____

Contact Information

3.	Can we call you at work?	YES	NO
	- Leave messages on work voice mail?	YES	NO
4.	Can we call your cell number?	YES	NO
	- Leave a message on your cell voicemail?	YES	NO
5.	Can we call your home phone?	YES	NO
	- Leave a message on your home phone	YES	NO
6.	Can we send you an e-mail?	YES	NO

Your e-mail address _____

Your home phone number ( ) _____

Your work phone number ( ) _____

Your cell phone number ( ) _____

Pharmacy information

Name of pharmacy

_____

Street name, and city or town pharmacy is located.

_____

Pharmacy phone number

_____

Patient Name (PRINT) _____

Patient Signature _____

Date _____

MT 12/27/09