PATIENT CONTACT FORM

Patient____ DOB_________________
Patient____ DOB_________________
Patient____ DOB_________________
Patient____ DOB_________________
Patient____ DOB_________________

At which of the following do we have permission to contact you?

Y/N Home _____________________ Y/N Work_____________________
Y/N Cell Phone__________________ Y/N Other_____________________
Y/N Email______________________

May we leave a message for you at work? Y/N May we send you email appointment reminders? Y/N

May we leave a message for you at home? Y/N May we send you text appointment reminders? Y/N

In addition to you and your insurance company, with whom may we discuss your child(ren)'s health information?

Relationship to Child(ren)		Primary Contact	**Emergency Contact**	**Release Records to**	**Resides With**
Spouse	Name/Phone___________________________________	Y/N	Y/N	Y/N	Y/N
Step Parent	Name/Phone___________________________________	Y/N	Y/N	Y/N	Y/N
Caregiver	Name/Phone___________________________________	Y/N	Y/N	Y/N	Y/N
Grandparent	Name/Phone___________________________________	Y/N	Y/N	Y/N	Y/N
Aunt/Uncle	Name/Phone___________________________________	Y/N	Y/N	Y/N	Y/N
Sitter/Nanny	Name/Phone___________________________________	Y/N	Y/N	Y/N	Y/N
Other	Name/Phone___________________________________	Y/N	Y/N	Y/N	Y/N

Do you have any health information that you would like to keep confidential from any person(s)? Y/N
If so, please describe:____
____

May we fax your child(ren)'s shot record to his/her school if requested? Y/N

____ ______________________________________
Name of School / Fax Number Name of School / Fax Number

I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information and the opportunity to specify alternative means of communication of my protected health information.

I acknowledge that I have read and received a copy of the Privacy Notice.

_____________________________________ ___________________
Parent/Guardian/Representative Signature Date

______________________________________ ___________________
Printed Name Relationship to Patient