



EAST LAKE
PLASTIC SURGERY CENTER

PATIENT PRIVACY QUESTIONNAIRE

Patient Name: _____ Today's Date: _____ Account #: _____

Patient SS#: _____

1. Please list the family members or significant others, if any, whom we may inform about your medical condition and your diagnosis (including treatment, payment and health care operations) **and** In Case of an Emergency:

Name: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
SS#: _____ DOB: _____
Phone #: _____ (PLEASE \checkmark IF) IN CASE OF EMERGENCY ONLY

Name: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
SS#: _____ DOB: _____
Phone #: _____ (PLEASE \checkmark IF) IN CASE OF EMERGENCY ONLY

Name: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
SS#: _____ DOB: _____
Phone #: _____ (PLEASE \checkmark IF) IN CASE OF EMERGENCY ONLY

2. Please print the **address** of where you would like your Billing Statements and/or correspondence from our office to be sent: _____ City: _____ State: _____ Zip: _____
3. Please indicate whether or not you would **want to receive phone calls** about your appointment reminders, follow-ups, test results, etc. YES NO

Please print the **telephone number** where you want to receive calls about your appointments, follow-up, test results or other health care information: please circle: home/work/cell* _____
**I am fully aware that a cell phone is not a secure and private line.*

4. Can **appointment reminders** be left on you telephone answering machine or voice mail? YES NO
5. Can **other confidential messages** (lab results, etc.) be left on your telephone answering machine or voice mail? YES NO

If YES, please indicate what types of messages may be left on your machine?
 Lab Results X-Ray Results Follow-up Needed

Patient/Legal Guardian Signature: _____ Date: _____

Witness: _____ Date: _____