

LITTLE ELM MEDICAL CLINIC
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PATIENT RECORD OF DISCLOSURES

Please check the **PRIMARY** telephone number, if any, where you want to receive information about your appointments, lab and x-ray results, or other healthcare information:

INITIALS

- () **Cell Phone:** _____ () **E-Mail** results to me at: _____
() Leave a message with detailed information ****Please note, emailing may not be secure for confidentiality****
() Leave message with call-back information () Leave a general message
() DO NOT LEAVE A MESSAGE () Leave message with call-back information
- () **Home Telephone:** _____ () **Written Communication:**
() Leave a message with detailed information () Mail to my home address (on demographics sheet)
() Leave message with call-back information () Mail to my work/office address:
() DO NOT LEAVE A MESSAGE _____
- () **Work Telephone:** _____ _____
() Leave Message with detailed information
() Leave message with call-back number only () **Other** (Spouse, Child, etc): _____
() DO NOT LEAVE A MESSAGE () DO NOT LEAVE A MESSAGE

PATIENT CONTACT QUESTIONNAIRE

Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis:

INITIALS

- Name: _____ Phone: _____
Name: _____ Phone: _____
() _____

ACKNOWLEDGEMENT RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

I acknowledge that this practice has provided me with a written copy of the **NOTICE OF PRIVACY PRACTICES**. I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy and ask questions.

INITIALS

- Patient Name: _____ Date of Birth: _____
Social Security Number: _____
Patient Signature: _____ Date: _____
Personal Representative/Legal Guardian Signature(if applicable): _____
Relation to Patient: _____