INFORMATION SHARING

NAME:_____ DATE:_____

HOW MAY WE CONTACT YOU?

HOME PHONE:_____ ☐ EMERGENCY ONLY ☐ ROUTINE ☐ OK TO LEAVE DETAILED MESSAGES

WORK PHONE:_____ ☐ EMERGENCY ONLY ☐ ROUTINE ☐ OK TO LEAVE DETAILED MESSAGES

CELL PHONE:_____ ☐ EMERGENCY ONLY ☐ ROUTINE ☐ OK TO LEAVE DETAILED MESSAGES

EMAIL:** _____ ☐ EMERGENCY ONLY ☐ ROUTINE ☐ OK TO LEAVE DETAILED MESSAGES

OTHER:_____ ☐ EMERGENCY ONLY ☐ ROUTINE ☐ OK TO LEAVE DETAILED MESSAGES

*****The more available you are to us, the more quickly we can provide you with important scheduling changes, visit reminders, laboratory results, peri-operative instructions, answers to your questions, etc.***

REFERRAL

Who referred you to our practice?

NAME:_____ Contact Info : _____ May we contact them? ☐ YES ☐ NO

LEGAL GUARDIAN

If you have appointed a legal guardian for your health and financial issues, please tell us who that is.

Guardian's Name:_____

PHYSICIANS / HEALTH CARE PROVIDERS

We believe it is in your best interest for us to know all the health care providers involved in your care, so that we may communicate relevant information in a timely fashion. Please list below all of your regular physicians and health care providers (including complimentary health care providers such as chiropractor, naturopath, dietician, and acupuncturist) with whom you are willing for us to communicate.

PROVIDER'S NAME	SPECIALTY	TELEPHONE NUMBER

FRIENDS AND FAMILY

Your privacy is very important to us. We can not share any information (including confirming appointment date and time) with anyone, including a spouse or care-giving child (unless they are your legal guardian) without your expressed permission. Please list below all persons with whom you will allow us to fully discuss your medical issues.

INDIVIDUAL'S NAME	RELATIONSHIP	TELEPHONE NUMBER

Signature of Patient (or legal guardian): _____