Specializing in the practice of
Radiation Oncology & Consultation
on Malignant Disease

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PATIENT QUESTIONNAIRE

1. PLEASE LIST THE FAMILY MEMBERS OR OTHER PERSONS, IF ANY, WHOM WE MAY INFORM ABOUT YOUR GENERAL MEDICAL CONDITION AND YOUR DIAGNOSIS (INCLUDING TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS):

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2. PLEASE LIST THE FAMILY MEMBERS OR SIGNIFICANT MEMBERS, IF ANY, WHOM WE MAY INFORM ABOUT TOUR MEDICAL CONDITION ONLY IN AN EMERGENCY.

NAME_____ PHONE NUMBER_____

NAME_____ PHONE NUMBER_____

3. PLEASE PRINT THE ADDRESS OF WHERE YOU WOULD LIKE YOUR BILLING STATEMENTS AND/OR CORRESPONDENCE FROM OUR OFFICE TO BE SENT IF OTHER THAN YOUR HOME.

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4. PLEASE INDICATE IF YOU WANT ALL CORRESPONDENCE FROM OUR OFFICE SENT IN A SEALED ENVELOPE MARKED "CONFIDENTIAL."

YES_____NO_____

5. PLEASE PRINT THE TELEPHONE NUMBER WHERE YOU WANT TO RECEIVE CALLS ABOUT YOUR APPOINTMENTS, LAB AND X-RAY RESULTS, OR OTHER HEALTH CARE INFORMATION IF OTHER THAN YOUR HOME PHONE NUMBER.

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I AM FULLY AWARE THAT A CELL PHONE IS NOT A SECURE AND PRIVATE LINE.

6 .CAN CONFIDENTIAL MESSAGES (I.E APPOINTMENT REMINDERS) BE LEFT ON YOUR TELEPHONE ANSWERING MACHINE OR VOICE MAIL?

YES_____NO_____

PATIENT NAME _____

PATIENT SIGNATURE _____

DATE _____