

Ballinger Clinic, PLLC

PATIENT CONTACT INFORMATION

Where would you prefer we contact you with **CONFIDENTIAL** information regarding your treatment or test results?

Please leave at least one number where we could leave you a message.

Home	Yes _____	Number _____	Voicemail okay? Yes ___ No ___
OR			Voicemail okay?
Work	Yes _____	Number _____	Yes ___ No ___
OR			Voicemail okay?
Cell	Yes _____	Number _____	Yes ___ No ___

I give permission for medical information about me to be shared with the following:

PRINT NAME

Patient or legally authorized individual signature

Date

Time

Printed name if signed on behalf of the patient

Relationship
(Parent, legal guardian, personal representative)

This form will be retained in your medical record.

Last Updated: 08.13.2009