500 W. Central Rd.
Suite 200
Mount Prospect, IL, 60056

PATIENT PRIVACY AND CONTACT INFORMATION

Patient Name: ________________________________ Date of Birth:____________________

Parent/Guardian Name: ____________________________________
(if patient is a minor or otherwise applicable)

1. Notice of Health Information has been read and/or received. Please sign below for Privacy Policy.

   ___________________________ ________ _______________________ ________
   Patient Date Parent/Guardian (if applicable) Date

2. How may we contact you?

   a. Home: ☐Yes ☐No Phone Number _______________________________

      May we leave a message? ☐Yes ☐No

      Please check those that apply: ☐Voicemail/Answering Machine ☐Family Member

   b. Cell: ☐Yes ☐No Phone Number _______________________________

      May we leave a message? ☐Yes ☐No

      Please check those that apply: ☐Voicemail/Answering Machine ☐Family Member

   c. Work: ☐Yes ☐No Phone Number _______________________________

      May we leave a message? ☐Yes ☐No

      Please check those that apply: ☐Voicemail/Answering Machine ☐Family Member

If you have specific instructions for us to note when leaving a message, please indicate below. We are required to keep all information confidential unless given specific instruction by the patient.

____
____
____
____

Initial ____________ Date _________