

OMAHA CHILDRENS CLINIC, P.C.**Patient Questionnaire**

Without your permission, we would be unable to even tell your spouse that you were in the building if they were to call. For example, if they were to meet you for your appointment and forgot the time, we would be unable to tell them.

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 options:

* _____

* _____

* _____

2. Please list the family members or significant others, if any, whom we may inform about your 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.

Street _____

City/State/Zip _____

4. Please list telephone numbers where we may reach you and leave general messages. For example, please call John at Dr. Doe's office.

* Home _____ *"I am fully aware a cell phone*

* Work _____ *is NOT a secure line"*

* Cell _____

* Other _____

PATIENT NAME _____ (guardian if under 18)

Patient/guardian signature Date