ADVANCED INTERVENTIONAL PAIN CONSULTANTS

FAMILY AND FRIENDS CONTACT FORM

Patient name:_____ Patient date of birth:_____

Persons who are involved in your care (family, friends, other doctors, etc.) may inquire about your treatment, lab results, prescriptions, etc. Please let us know who we may share information with. (Please note: In emergency situations or other situations outlined in our Notice of Privacy Practice we may share information with others who are not specifically listed on this form.)

Please list other people (including Family, Friends, Previous Treating Physicians, your Family Doctor (PCP), and other doctors/specialists) with whom we may share your information:

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Name: _____ Relationship:_____

What is the best phone number for us to contact **you**? _____

What is your **e-mail** address?_____

From time to time we will leave a message for you on an answering machine, voice mail, or with another individual in your absence. Is it OK for such message to include details such as diagnosis and medication information at this number? _____

What other ways may we contact you? Please list any that are acceptable to you.

Home #: _____Is it OK to leave a detailed message at his number in your absence?_____

Work #: _____Is it OK to leave a detailed message at his number in your absence?_____

Cell #: _____Is it OK to leave a detailed message at his number in your absence?_____

Other #: _____Is it OK to leave a detailed message at his number in your absence?_____

_____ _____

Signature of Patient or Legal Representative **Date**

_____ _____

Print name of Patient or Legal Representative **Relationship to patient**