

# Asthma & Allergy Associates P.C.

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## PATIENT PRIVACY METHOD OF CONTACT INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ Account #: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Email: \_\_\_\_\_

You may contact me or my legal guardian in the following manner:

I have indicated in numeric order my preferences with a 1 as my preferred method of contact, followed by a 2 and 3.

### Appointment Information

Home Phone (Include Auto Call) \_\_\_\_\_

Mobile Phone (Include Auto Call) \_\_\_\_\_

Mobile Text (Auto Text) \_\_\_\_\_

Send via Mail \_\_\_\_\_

Send via Patient Portal/Email \_\_\_\_\_

### Medical Information

Home Phone (Include Auto Call) \_\_\_\_\_

Mobile Phone (Include Auto Call) \_\_\_\_\_

Mobile Text (Auto Text) \_\_\_\_\_

Send via Mail \_\_\_\_\_

Send via Patient Portal  
(must have portal) \_\_\_\_\_

Listed below are the individual(s) you may communicate with regarding my health care. This is other than/in addition to those parent(s) or legal guardian(s) who have signed this authorization below.

1) Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Emergency Phone Number: \_\_\_\_\_ Please Specify: \_\_\_ Home \_\_\_ Mobile

2) Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Emergency Phone Number: \_\_\_\_\_ Please Specify: \_\_\_ Home \_\_\_ Mobile

Patient/Legal Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name if Above is a Legal Representative: \_\_\_\_\_

Relationship to the Patient: \_\_\_\_\_

Expiration Date of Consent: Until Rescinded

Activity 3: Contact Information

Write down the contact information for the person you are working with. This includes their name, phone number, and email address. You will need this information to contact them if you have any questions or need to discuss your work.

CONTACT INFORMATION

Name: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Email: \_\_\_\_\_

You will need to contact your partner at least once a week to discuss your work. Please make sure you have their contact information on hand at all times.

Medical Information: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_

Work Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Send to: \_\_\_\_\_

Send to: \_\_\_\_\_

Send to: \_\_\_\_\_

Send to: \_\_\_\_\_

Send to: \_\_\_\_\_

Send to: \_\_\_\_\_

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Send to: \_\_\_\_\_