

MARC W. URQUHART, M.D.
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PATIENT CONFIDENTIALITY

In this office, Patient Confidentiality is a prime concern. Please indicate below with whom our office can or cannot leave a message. Please check where appropriate.

If Patient is a minor: Parent/Legal Guardian

Print Name

Signature

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	<u>Yes</u>	<u>No</u>	<u>Does Not Apply</u>
Spouse	___	___	___
Parent	___	___	___
Children	___	___	___
Answering Machine	___	___	___
Home	___	___	___
Work	___	___	___

Are you able to receive telephone calls at your work place? Yes ___ No ___

May we call you at your work place and state who is calling? Yes ___ No ___

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Do to confidentiality regulations; should a family member, friend or relative contact our office, we are not at liberty to discuss your situation unless we have permission from you, the patient.

Please check with whom we may discuss your situation:

	<u>Yes</u>	<u>No</u>	<u>Name of Person</u>
Spouse	___	___	_____
Children	___	___	_____
Parent	___	___	_____

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Emergency Contact

Person to contact in case of emergency: (Parent, Children, Spouse & or Significant Other)

Name _____

Name _____

Relationship _____

Relationship _____

Phone _____

Phone _____

Primary Care Physician: _____

Address _____

Phone number _____