Tampa Office
6101 Webb Road Suite 303
Tampa, FL 33615-2866
Phone (813) 885-5888
Fax # (813) 885-5889

Active Orthopedics

PATIENT QUESTIONNAIRE

I. Please list the family members or other persons, if any, whom we may inform about you general medical condition and your diagnosis (including treatment, payment and health care operation):

_____

_____

II. Please list the family members or significant others, if any, whom we may inform about your medical condition **ONLY IF AN EMERGENCY:**

_____

_____

III. 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.

_____

_____

IV. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL": YES_____ NO_____

V. Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other health care information of other than your home phone number:

_____

VI. Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voicemail? YES_____ NO_____

PATIENT NAME _____(guardian if under 18 years)

_____ _____

PATIENT /FUARDIAN SIGNATURE DATE