



Radiation Oncology
Dr. William D. Permenter
Dr. Paul Koerner

Medical Oncology / Hematology
Dr. Brian Walker
Dr. Archie Wright

PATIENT QUESTIONNAIRE

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 OPERATIONS):

2. PLEASE LIST THE FAMILY MEMBERS OR SIGNIFICANT MEMBERS, 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.

4. PLEASE INDICATE IF YOU WANT ALL CORRESPONDENCE FROM OUR OFFICE SENT IN A SEALED ENVELOPE MARKED "CONFIDENTIAL."

YES _____ NO _____

5. PLEASE PRINT THE TELEPHONE NUMBER WHERE YOU WANT TO RECEIVE CALLS ABOUT YOUR APPOINTMENTS, LAB AND X-RAY RESULTS, OR OTHER HEALTH CARE INFORMATION IF OTHER THAN YOUR HOME PHONE NUMBER.

I AM FULLY AWARE THAT A CELL PHONE IS NOT A SECURE AND PRIVATE LINE.

6. CAN CONFIDENTIAL MESSAGES (I.E APPOINTMENT REMINDERS) BE LEFT ON YOUR TELEPHONE ANSWERING MACHINE OR VOICE MAIL?

YES _____ NO _____

PATIENT NAME _____

PATIENT SIGNATURE _____

DATE _____