ACCELERATED RECOVERY SPECIALISTS
Musculoskeletal & Electrodiagnostic Medicine

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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, appointments, and health care operations. (In addition to worker's compensation and auto insurance adjusters who legally have access to this information).

   Name _____ Relationship _____

   Name _____ Relationship _____

   Name _____ Relationship _____

   Name _____ Relationship _____

2. Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other information if other than your home phone number _____

3. Can confidential messages be left at the number given above or on your telephone answering machine? ❍ Yes ❍ No

I am fully aware my health information can be transmitted by electronic transmission, by fax transmittal, by internet or by e-mail.

Patient Signature_____ Date_____