# Cherry Bend Family Care Health Information Check List

Patient Name:_____ Patient Date of Birth:_____

Social Security # _____

I authorize the physicians and staff at Cherry Bend Family Care to impart my personal health information to me in the following manner: **Please check ALL that apply.**

_____ OK to email me test results – medical information and/or instructions via our secure Patient Portal. If you do not receive your test results from our office within a reasonable time (2-3 weeks), please call our office.
EMAIL ADDRESS: _____

_____ OK to leave *detailed messages* on my answering machine or voice mail
Details of test results – appointment dates/times – medical information and/or directions.
PHONE: _____ Alternate Phone: _____

_____ OK to leave *brief messages* on my answering machine or voice mail
"test results are normal" – "confirming next day office appointment"

_____ OK to discuss my test results, medical information and/or directions with:
Name & Relationship _____ Contact # _____

Name & Relationship _____ Contact # _____

_____ OK to send an open post card reminding me to call the office/schedule appointment.

_____ OK to call me on my cell phone. CELL #: _____

_____ DO NOT CONTACT ME AT HOME. Please contact me at:
_____

Name and Relationship of Emergency Contact: _____
Phone #: _____

Patient Signature: Date: