Gainesville Internal Medicine Physicians

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Patient Communication Form

PLEASE PRINT CLEARLY

Patient Name: ___________________________________ Date of Birth: ________________

Address: ____

We believe that good communication is key to a strong patient-physician relationship. If we send you for a blood test or radiology study we will notify you of the results. Please list the telephone number you would like us to call-in order of preference.

CONTACT NUMBERS: Okay to leave voicemail message

1) Home/Work/Cell __________________________Yes__________No_________
2) Home/Work/Cell ___________________________Yes__________No_________
3) Home/Work/Cell ___________________________Yes__________No_________

EMAIL ADDRESS: ____

I give permission for the following family members, significant other, etc. to receive information about my test results, referrals, medical condition, etc.

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I understand that on occasion, due to technical problems with mailing, faxing, etc, my provider may not have received my test results when expected. If I have not been notified of my results within 1 week of the test it is my responsibility to telephone the office to follow-up.

I understand that I am responsible for notifying this office of any change in the above information.

____ ________________________
Signature Date