PLEASE FILL IN ALL APPLICABLE BLANKS AND SIGN THE BOTTOM.

Jennifer Aldrich M.D. P.A.
8335 Walnut Hill Ln. Ste, 100
Dallas, TX 75231
214-382-5810
855-479-1759

PATIENT HIPAA 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):

_____

NAME RELATIONSHIP PHONE #

_____

NAME RELATIONSHIP PHONE #

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

_____

NAME RELATIONSHIP PHONE #

3. Please list where you would like your billing statements and/or correspondence from our office to be sent **if** other than your home.

_____

4. Please print the telephone number where you want to receive calls about your appointments, labs and x-ray results or other health information.

_____

5. Can confidential messages be left on your voicemail at the number above? Yes____ or No____
6. I am fully aware that a cell phone is not a secure and private line.
7. I am fully aware my health information can only be transmitted by fax or email if Jennifer Aldrich M.D. is provided authorization.
8. I hereby grant permission to the provider to view my prescription history from external sources

Print Name _____ **Date** _____

Patient Signature

_____