

SUNWEST GYNECOLOGY ASSOCIATES
7430 REMCON CIRCLE BLDG. B STE. 100
EL PASO TX 79912
915-541-1144

PATIENT QUESTIONNAIRE

I. 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):

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

Name: _____ Phone #: _____
Name: _____ Phone #: _____

III. 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:

IV. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL":

YES _____ NO _____

V. Please print the telephone number where you want to receive calls about your appointments, lab, 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 *

VI. Can confidential messages (appointment reminders, results, etc.) be left on your telephone answering machine or voice mail?

YES _____ NO _____

VII. May we use your email address and/or text messaging to send you information regarding general notices, including reminder of appointments patient satisfaction surveys, and clinic newsletters?
(I have read the electronic communication permission form and understand that a copy can be given to me)

YES _____ NO _____

Email Address _____ **Cell Phone** _____

PATIENT NAME: _____ (guardian if under 18 years of age)

PATIENT/GUARDIAN SIGNATURE

DATE