PATIENT CONTACT INFORMATION

PATIENT LAST NAME_______________________FIRST NAME________________DOB________

BEST TELEPHONE NUMBERS TO CONTACT YOU
CELL___________________ HOME____________________ WORK______________________

INFORMED CONSENT / PRIVACY MANAGEMENT FOR CONFIDENTALITY

Please review this document and let us know how we may contact you, and the other persons (family members, friends, care takers) we may contact to discuss your medical care.

Mountain View Rehabilitation Medical may leave a message as follows:

Home voice mail yes____ no____ Detailed message OK? ________________

Cell phone voice mail? yes____ no____ Detailed message OK? ________________

Work voice mail? yes____ no____ Detailed message OK? ________________

List the persons you authorize Mountain View to discuss your medical care with and/or release medical information to. Please list their names, relationship to you and telephone numbers

Name__________________________ relationship ____________Telephone #___________

Name __________________________relationship ____________Telephone #___________

EMERGENCY CONTACT INFORMATION

Names and contact information of persons we may contact in case of an emergency:

Name ________________________________ ____________________________________
Phone: _______________________________ ____________________________________
Address: ______________________________ ____________________________________
______________________________________ ____________________________________

PATIENT SIGNATURE ____ DATE ____________