



North Louisiana
**Orthopaedic &
Sports Medicine Clinic**

Experience You Can Trust Since 1951

Patient 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, releasing your medical records, and healthcare operations):

Name _____ Relationship _____ Phone number _____

Name _____ Relationship _____ Phone number _____

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 number _____

Name _____ Relationship _____ Phone number _____

3. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent: _____

4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL":
Yes _____ No _____

5. Please print the alternative daytime telephone number (s) where you would like to receive communications regarding your appointments, lab, and x-ray results, and other healthcare information:

() _____ () _____

I am aware that a cellular phone is not a secure and private line.

6. Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voicemail?

Yes _____ No _____

7. Would you be interested in receiving orthopedic educational information via email?

Email addr. _____ Yes _____ No _____

PATIENT NAME _____

Patient/Guardian (if under 18) Signature Date