



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, 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 if other than your home address.

\_\_\_\_\_

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 orthopaedic educational information via email?

Email Address \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_

\_\_\_\_\_  
**PATIENT NAME**

\_\_\_\_\_  
**PATIENT/GUARDIAN SIGNATURE**

\_\_\_\_\_  
**DATE**

*North Louisiana Orthopaedic & Sports Medicine Clinic complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.*