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Patient Communication Preference

You can type directly into the shaded fields on a computer, or print this form and fill it in by hand. Please sign and date where indicated.

Patient Name: _____

I would like to be contacted in reference to care (please check all boxes that apply):

Home Telephone #: _____

- ☐ OK to leave a message with detailed information
- ☐ Please leave a message with call back number only

Business Telephone #: _____

- ☐ OK to leave a message with detailed information
- ☐ Please leave a message with call back number only

Cell Phone #: _____

- ☐ OK to leave a message with detailed information
- ☐ Please leave a message with call back number only
- ☐ OK to send text message with detailed information

Email Address: _____

- ☐ OK to email

Please note: Your email will not be shared with third parties and will strictly be used for communication and alerts within the practice.