

Patient Privacy Questionnaire (HIPPA)
Physician's Weight Control and Wellness Centers

Otto Puempel, D.O.

Patrick Kirlin, D.O.

Dale Allen, M.D.

Christopher Puempel, M.D.

Michael Boothe, M.D.

Heather Newman, RN, MS, FNP

Arlington ~ Dallas ~ Waco

Name of patient _____

Names and contact numbers of persons, if any, we may contact in an emergency.

If you would like correspondence from our office sent to an address other than your home please specify.

Are there any special instructions how correspondence may be sent to you? _____

Please provide an e-mail address we could send correspondence to. _____

Would you like to have our newsletters e-mailed to you? Yes _____ No _____

* **May we e-mail an appointment reminder to you?** Yes _____ No _____

List the telephone numbers where we may call you. If you do not want to be called at a certain number do not list that number. Cell phones, voicemail, and answering machines are not completely private.

Home Phone _____

May we leave a message on the answering machine? Yes _____ No _____

If someone answers your home phone may we leave a message with that person? Yes _____ No _____

Cell Phone _____

May we leave a message on voice mail? Yes _____ No _____

Work Phone _____

May we leave a message on voice mail? Yes _____ No _____

PATIENT'S NAME (please print) _____

SIGNATURE _____ DATE _____

NOTE: This signed Privacy Questionnaire will remain in your file and considered current. If there are any changes you must notify our office and complete another form.