Doctor & Patients Communication

Name of Patient: _____
(please print)

Date of Birth: _____

I request that all communications to me (by telephone, mail or otherwise) by Southwest Foot Institute and/or it's staff be handled in the following manner.

- For written communication: Send to: ❑ Home Address
  ❑ Other _____
  _____
  _____

- For oral communications: Contact Person: _____
  May we leave a message?
  Yes ❑ No ❑

- I understand due to privacy issues no lab or test results will be left on an answering machine.
  Initial _____

If the address provided above is not your home address or is not a street address, please provide us with a street address for purpose of ensuring payment:

_____
_____
_____

_____
Patient Signature

_____
Date