NEW PATIENT QUESTIONNAIRE

1. Please list the family members or other persons, if any, whom we may inform about your generalmedical conditions and your diagnosis
   ____
   ____

2. Please list the family members or significant others, if any, whom we may inform about your medical conditions ONLY IN EMERGENCY:
   a. Name: ________________________________ Phone Number: ____________________
   b. Name: ________________________________ 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:
   ____

4. Please indicate if you want all your correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL" Yes______ No _______

5. Please print the telephone number where you want to receive calls about your appointment, lab, and x-ray results, or other health care information if other than your home phone number:
   _________________________**"I am fully aware that a cell phone is not a secure and private line."**

6. Can confidential messages (i.e. appointments reminders) be left on your telephone answering machine or voicemail? Yes ________ No _______**(If no, you will not receive an appointment reminder.)**

7. I have been given a copy of my Patients Rights and Responsibilities. Yes ____

8. I have been given a copy of the Joint Notice of Privacy Practices. Yes ____

9. Advance Directives:
   Do you have a Health Care Power of Attorney? Yes____ No____
   Living Will? Yes____ No____
   Have you supplied us with a copy? Yes____ No____

Patient OR Guardian Signature____ Date: &DATE

Clinic Employee Witness:____ Date: &DATE

CAPE FEAR VALLEY
UROLOGY

Patient Name ______________________________

DOB ______________________________________

Chart # ___________________________________

PCP FORM 018 NPP PATIENT QUESTIONNAIRE