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## Patient Contact Form

Name of patient \_\_\_\_\_ Date \_\_\_\_\_

All calls regarding your care, test results, and appointments will be made to your home telephone number. If you would like us to contact you at an alternate telephone number, please indicate that telephone number here:

(\_\_\_\_) \_\_\_\_\_

\_\_\_\_\_ I hereby authorize this medical practice to contact me by telephone and if I am not present, they may leave a message on my answering machine.

\_\_\_\_\_ Do **NOT** leave messages on answering machine other than name of caller and telephone number.

**Other Contact Information**

The following people other than a duly designated guardian or conservator are authorized to discuss my medical condition or billing information with a healthcare professional in this practice:

Name	Relationship	Telephone Number
Name	Relationship	Telephone Number
Name	Relationship	Telephone Number

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_ Telephone Number \_\_\_\_\_

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**For office Use Only**

Signed form received by (Please Print) \_\_\_\_\_ Date \_\_\_\_\_