

John P. Kinney, M.D.
Oren Lifshitz, M.D.
4477 Medical Center Way, Suite A
West Palm Beach Florida 33407
561-840-7977

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 _____