JENNIFER FONTIUS, MD
Family Medicine

NAME: ____ **DOB:** __________________

MAILING ADDRESS:

Street: ____ Unit#: __________________

City: ______________________________________ State: ____________ Zip:______________

CONTACT INFORMATION:

Cell: ________________________________ Home: ______________________________

Work: _______________________________

Email (for our use only): ____

DO YOU GIVE US PERMISSION TO LEAVE MESSAGES , RESULTS ON VOICEMAIL? Y/N

If yes, which number? ______________________________

List anyone else we may give results to: _____________________Tel:_____________________

EMERGENCY CONTACT:

Name: ______________________________ Relationship: ______________________________

Tel number: ____

HIPAA: By initialing, you acknowledge receipt of our Notice of Privacy Practices and Patient Rights. ______

By signing below, you acknowledge and agree to these terms.

PATIENT/GUARANTOR NAME: ____

SIGNATURE: ____________________________________ **DATE:** __________________