NORTHERN KENTUCKY EYE CENTER

Patient Name: _____

I acknowledge that I have received or have been offered a copy of Sharon M. Schaffield, O.D.'s Notice of Privacy Practices.

Because we value your privacy, please list the names of any family member or friend who is permitted to discuss your care.

_____

_____

Home Phone Number _____ **Is it okay if we leave a message on your answering machine? Yes or No**

Is it okay if we call you at work? Yes or No and Work Phone No. _____

Do you have a cell phone? If so, please provide the number if it is okay to contact you by cell phone

_____

Please circle the phone number where you would prefer us to contact you.

Patient Signature _____ **Date** _____
(Or if minor, signature of adult accompanying patient)