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Primary Care Physician



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PATIENT QUESTIONNAIRE

I. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operation):

II. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

Name_____ Phone Number_____

Name_____ Phone Number_____

III. 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.

IV. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL":

YES_____ NO_____

V. Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other health care information if other than your home phone number:_____

VI. Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voicemail?

YES_____ NO_____

PATIENT NAME_____ (guardian if under 18 years)

(PATIENT/GUARDIAN SIGNATURE)

(DATE)

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