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DR. WAGNER, M.D., F.A.C.S & DWIGHT BIRKLEY, M.S., PA-C

Request for Alternative Communication

DATE: ___________________

NAME: _________________________________DATE OF BIRTH: _____/_____/_____

Communications to Family Members and Others Involved in My Healthcare:

Name 1: ______________________ ___________________ ______________________
Relationship **Phone No**

Name 2: ______________________ ___________________ ______________________
Relationship **Phone No**

Name 3: ______________________ ___________________ ______________________
Relationship **Phone No**

I understand that it is my responsibility to update the above information if I want it changed. This communication information will be used for all medical conditions and treatment obtained at Wagner Ear Nose & Throat.

Standard Methods to Communicate to Me (the patient)

Detailed information regarding my medical condition and medical treatment may be left on:

My Home Answering Machine ____ YES ____ NO
My Cell Phone ____ YES ____NO

____ ____________________________
Signature of Patient or Legal Guardian Date

____
Relationship (if not patient)