WAGNER
EAR NOSE & THROAT

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SIOUX CITY, IA 51104

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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)