Chandan Saw, DO

Personalized Pulmonary Care

PATIENT INFORMATION

This information will be placed in your confidential medical record and will be used exclusively by **Chandan Saw, DO** to facilitate your care.

PLEASE PRINT -- THANK YOU!

_____ _____ _____

Last Name **First Name** **M.I.**

_____ _____

Address **City, State, Zip**

_____ _____

Date of Birth **Name of Spouse/Partner (Full Name)**

_____ _____ _____

Home Phone # **Work Phone #** **Cell Phone #**

_____ _____ _____

Patient E-mail Address **Pharmacy Name** **Pharmacy Phone #**

Please indicate your preferred contact phone # (circle one): **Home Work Cell**

May we leave a detailed message at your preferred phone #? **Yes No**

In addition to yourself, to whom may we release your medical information?

Please list name (s) and their relationship to you: _____

_____

_____ I prefer that you address any issues related to my medical care only with me.

Do you check your email on a regular basis? **Yes No**

Do you use and are you comfortable communicating via text messaging? **Yes No**

EMERGENCY CONTACT INFORMATION

Please indicate an emergency contact with whom we may share necessary information regarding you with this person:

_____ _____ _____

Last Name **First Name** **Relationship**

_____ _____

Home Phone # **Other Phone #**

_____/_____/_____

Name of individual completing this form **Signature** **Date**

Please complete ALL information and return to Chandan Saw, DO.