**Oak Hills Women’s Center, P.A.**

Allison R. Cavazos M.D.

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9639 Huebner Rd.

San Antonio, Texas 78240

**Patient Questionnaire**

Please list the family members or other persons, if any, whom we may inform about your general medical conditions and your diagnosis:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list the family members or significant other, if any, whom we may inform about your medical condition ONLY IN AN EMERGNECY:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please print the address of where you would like billing statements and/or correspondence from our office to be sent if other than your home:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate if you want all correspondence from our office sent in a sealed envelope marked “CONFIDENTIAL” YES: \_\_\_\_\_\_ NO: \_\_\_\_\_\_\_

Please print the telephone number, if any, 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:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Can confidential messages (i.e. appointment reminders) be left on your home answering machine or voicemail? YES: \_\_\_\_\_\_ No: \_\_\_\_\_\_

If you do not have a voicemail, can a confidential message be left at your place of employment? YES: \_\_\_\_\_\_ No: \_\_\_\_\_\_

**Patient Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Guardian if under 18 yrs.)

**Patient/Guardian Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_