



Patient Name: _____

DOB: _____

Telephone Communication Instructions

I give my permission for Sonoran Sky Pediatrics to leave a voice message at the indicated telephone numbers for appointment reminders or rescheduling, billing questions, and for the results of routine or normal lab and X-ray. I understand that some confidential health information may be a part of the message.

1. Appointment reminders, rescheduling, etc.

cell phone home phone other: _____

message may include confidential information

Do NOT leave a message with confidential information

2. Billing questions

cell phone home phone other: _____

message may include confidential information

Do NOT leave a message with confidential information

3. Lab or X-ray results

cell phone home phone other: _____

message may include confidential information

Do NOT leave a message with confidential information

Signed: _____

Date: _____

Pharmacy Information

Preferred pharmacy: _____

Cross streets: _____

Telephone number: _____