

North Jersey Orthopaedic Specialists, P.A.

PATIENT RECORD of DISCLOSURES

I wish to be contacted in the following manner (check all the apply):

Home Telephone

O.K. to leave a message with detailed information
 Leave message with call-back number only

Work Telephone

O.K. to leave message with detailed information
 Leave message with call-back number only

Written Communication

O.K. to mail to home address
 O.K. to mail to my work/office address
 O.K. to fax to number listed below:

Other

Patient/Guardian Signature: _____ Date: _____

Patient Name: _____ Date of Birth: _____