

WISDO FAMILY MEDICINE

James John Wisdo, D.O., P.A.

Christine A Kogoy, PA-C

Patient Contact Information

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

Home Telephone # _____

OK to leave a message with detailed information

Leave message with call back number only

Work Telephone # _____

OK to leave a message with detailed information

Leave message with call back number only

Cell Phone # _____

OK to leave a message with detailed information

Leave message with call back number only

Personal Contacts

OK to release Protected Health Information (PHI) to the following person(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand it is my responsibility to change this information should circumstances change. I will notify Wisdo Family Medicine, in writing of any changes to the above.

Print Patient Name _____

Patient Signature _____ Date _____

James John Wisdo, D.O.

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