David Bub, MD, PC, FACS, FASCRS

Contact Information Form

HIPAA PRIVACY INFORMATION:

In accordance with HIPAA guidelines, we will be sending all appointment reminders, statements, reports, etc. to you via mail or email unless otherwise instructed by you or your representative.

I authorize Dr. Bub and/or his staff to leave appointment and/or medical information:

Phone #/Email Address	Appointment Information	Medical Information
Home: _____	**Yes** or **No**	**Yes** or **No**
Mobile: _____	**Yes** or **No**	**Yes** or **No**
Mobile Text: _____	**Yes** or **No**	**Yes** or **No**
Work: _____	**Yes** or **No**	**Yes** or **No**
With another person: **Name: _____** **#: _____**	**Yes** or **No**	**Yes** or **No**
Via Email: _____	**Yes** or **No**	**Yes** or **No**
Via Portal:	**Yes** or **No**	**Yes** or **No**
Via Mail (USPS):	**Yes** or **No**	**Yes** or **No**

Pharmacy (name, location and/or phone #) _____

Emergency Contact Information:

Name	Phone#	Relationship
_____		
_____		
_____		

Printed name of patient:_____Date:_____

Signature of patient/guardian: _____