Gjorgji Trnovski, M.D.

Diplomate American Board of Internal Medicine

PATIENT CONTACT FORM

DATE_____

I, _____, authorize the staff to

(Print Name)

contact me by the following options below that I have checked:

Leave a detailed message at my phone number listed below

Leave a message with anyone answering the phone

Speak with only me

List any person(s) authorized to accept results for me:

_____

_____

_____ _____

Patient's Preferred Phone Number Patient's Alternate Phone Number

Patient Signature_____

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