

**NUTRITION ADVANTAGE, LLC**  
**Deborah Serenius, RD, LD**

<b>Patient Contact Questionnaire</b>
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I. Please list the family members of other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment and payment):

NAME: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

NAME: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

II. Please list the family members or significant others whom we may inform about your medical condition ONLY IN AN EMERGENCY:

NAME: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

NAME: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_