

**SADIA R. CHAUDRY, MD LLC**  
**526 BLOOMFIELD AVE, SUITE 102**  
**CALDWELL, NJ 07006**  
**(973) 228-1377**

**PREFERENCE FOR COMMUNICATION**

We are committed to providing private and efficient communication with you regarding your medical care and our office communication. **Please complete the following information as specifically as possible and initial at each X.** This allows us to communicate with you based on your preferences. Federal regulations require us to ask you to complete this form. Thank you.

**If we need to reach you by phone:**

-May we call you at: Home  yes  no number \_\_\_\_\_  
Work  yes  no number \_\_\_\_\_  
Cell  yes  no number \_\_\_\_\_  
Other  yes  no number \_\_\_\_\_

Initials X \_\_\_\_\_

-May we leave a message:

With another person  yes  no  
If so, name \_\_\_\_\_ number \_\_\_\_\_  
On voice mail/answering machine  yes  no

Initials X \_\_\_\_\_

-If we may leave a message, what type of message would you prefer?

Detailed (labs results, appointments, etc.)  yes  no  
Request only for you to return our call  yes  no  
Preferred number for messages \_\_\_\_\_

Initials X \_\_\_\_\_

**If we have routine, non-urgent matters to bring to your attention, where would you like to receive mail?**

Home  yes  no Address: \_\_\_\_\_  
Other  yes  no \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Initials X \_\_\_\_\_

Please add any information you feel would be helpful in facilitating our communication with you.

Printed Name \_\_\_\_\_

Signature \_\_\_\_\_

Date Signed \_\_\_\_\_

Chart Number \_\_\_\_\_