



**Patient Information (Please print with pen)**

|                             |                       |   |   |  |
|-----------------------------|-----------------------|---|---|--|
| Legal Last Name:            | Legal First Name:     | Middle Name:  | SSN:  |  |
| Mailing Address:            | City:                 | State:  | Zip:  | Email Address:   |
| Home Telephone:             | Cell Phone:           | Other Phone:  | Gender:<br><input type="checkbox"/> M <input type="checkbox"/> F          | Status: <input type="checkbox"/> Married <input type="checkbox"/> Single<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |
| Date of Birth (mm-dd-yyyy): | Date of Injury/Onset: | Work Related:<br><input type="checkbox"/> Yes <input type="checkbox"/> No | Auto Related:<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |

**Physician Information**

|  |  |                                    |
|--|--|------------------------------------|
| Primary Care Physician (PCP):                | City/State of PCP:                                       | Physician who referred you here:   |
| May we send medical information to your PCP? | <input type="checkbox"/> Yes <input type="checkbox"/> No | City/State of Referring Physician: |

**Employer Information**

|           |                 |   |
|-----------|-----------------|---|
| Employer: | Employer Phone: | Employment Status: <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Self <input type="checkbox"/> Retired<br><input type="checkbox"/> Student <input type="checkbox"/> None |
| Address:  | City:           | State: Zip:   |

**Responsible Party (For Minors and/or Dependents for Insurance Purposes)**

|  |             |                         |
|--|-------------|-------------------------|
| If Minor, Does child live with: <input type="checkbox"/> Both Parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____ |             |                         |
| Mother's Full Legal Name:  | Home Phone: | Address (if different): |
| Date of Birth:   | Employer:   |                         |
| Father's Full Legal Name:  | Home Phone: | Address (if different): |
| Date of Birth:   | Employer:   |                         |

**Emergency Contact**

|               |        |               |
|---------------|--------|---------------|
| Contact Name: | Phone: | Relationship: |
|---------------|--------|---------------|

**Health Care Primary Insurance**

|                    |   |          |         |
|--------------------|---|----------|---------|
| Name of Insurance: | Policy or Claim #:  | Group #: | Co-pay: |
| Policy Holder:     | Date of Birth (mm-dd-yyyy):   |          |         |
| Employers Name:    | Relationship to patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse<br><input type="checkbox"/> Dependent <input type="checkbox"/> Other |          |         |

**Secondary Insurance**

|                    |   |          |         |
|--------------------|---|----------|---------|
| Name of Insurance: | Policy or Claim #:  | Group #: | Co-pay: |
| Policy Holder:     | Date of Birth (mm-dd-yyyy):   |          |         |
| Employers Name:    | Relationship to patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse<br><input type="checkbox"/> Dependent <input type="checkbox"/> Other |          |         |

# Chiropractic Medical Questionnaire

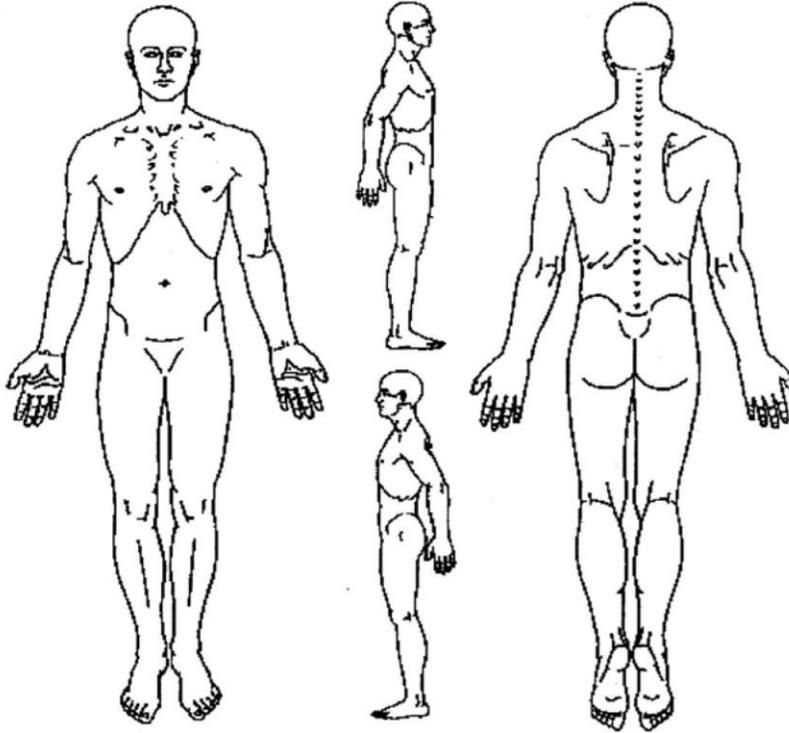
Patient Name (Print) \_\_\_\_\_ Date \_\_\_\_\_

Age: \_\_\_\_\_ Gender: F M Dominant Hand: R L Who referred you to this office? \_\_\_\_\_

May we contact your Family Doctor? Y N What is the main reason for this visit? \_\_\_\_\_

On the diagram below, please indicate where you are experiencing pain right now and use the appropriate symbol as indicated

**A = Ache    B = Burning    N = Numbness    P = Pain    PN = Pins & Needles    S = Stabbing    SF = Stiffness    W = Weakness    O = Other**



**Please make a slash through this line as to the level of your current pain**

No Pain At All  $\curvearrowright$ ----- $\curvearrowleft$  Worst Pain Possible

Rate the **severity** of your pain from 1 (least pain) to 10 (most pain) (circle)    0    1    2    3    4    5    6    7    8    9    10

What is the **type** of your pain?    Sharp    Dull    Stabbing    Throbbing    Aching    Burning

Is your pain:    Constant    Intermittent (comes and goes)    Shooting    Cramping    Tingling

Does your pain awake you from sleep? Y N    Does your pain interfere with your daily routine/recreation? Y N

Estimate the average hours of sleep each night: \_\_\_\_\_ Estimate how many times you are awakened each night \_\_\_\_\_

Do you have:    Numbness    Weakness    Swelling    Weight Changes    Changes in bowel/bladder frequency or urgency    Night Sweats

Dizziness    Lightheadedness    Stiffness    Bruising    Loss of control of bowel or bladder functioning

Since your problem started is it:    Getting Better    Getting Worse    Unchanged

What makes your symptoms **worse**?    Sitting    Standing    Walking    Lifting    Exercise    Twisting    Bending    Squatting    Kneeling    Coughing

Sneezing    Looking Up    Looking Down    Using Stairs: Up    Down    Both

What makes your symptoms **better**?    Rest    Stretching    Ice    Heat    Position \_\_\_\_\_    Other \_\_\_\_\_

Have you taken any medications/OTC medications today? Y N Last time taken? \_\_\_\_\_

What Medications/Vitamins are you currently taking? Please list with dosage: \_\_\_\_\_

Have you seen any other healthcare provider for this condition? If yes, who? \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_ (Performed by Doctor)

# Blando Chiropractic

## CHIROPRACTIC HEALTH AND FAMILY HISTORY FORM

### HEALTH HISTORY

Have you had any of the following:

|               |        |                |        |               |        |                 |        |
|---------------|--------|----------------|--------|---------------|--------|-----------------|--------|
| AIDS/HIV      | Yes No | Emphysema      | Yes No | Miscarriage   | Yes No | Scarlet Fever   | Yes No |
| Alcoholism    | Yes No | Epilepsy       | Yes No | Mononucleosis | Yes No | Stroke          | Yes No |
| Allergy Shots | Yes No | Fractures      | Yes No | Multiple      |        | Suicide Attempt | Yes No |
| Anemia        | Yes No | Glaucoma       | Yes No | Sclerosis     | Yes No | Thyroid         |        |
| Anorexia      | Yes No | Goiter         | Yes No | Mumps         | Yes No | Problems        | Yes No |
| Appendicitis  | Yes No | Gonorrhea      | Yes No | Osteoporosis  | Yes No | Tonsillitis     | Yes No |
| Arthritis     | Yes No | Gout           | Yes No | Pacemaker     | Yes No | Tuberculosis    | Yes No |
| Asthma        | Yes No | Headaches      | Yes No | Parkinson's   |        | Tumors,         |        |
| Bleeding      |        | Heart Disease  | Yes No | Disease       | Yes No | Growths         | Yes No |
| Disorders     | Yes No | Hepatitis      | Yes No | Pinched Nerve | Yes No | Typhoid Fever   | Yes No |
| Breast Lump   | Yes No | Hernia         | Yes No | Pneumonia     | Yes No | Ulcers          | Yes No |
| Bronchitis    | Yes No | Herniated Disk | Yes No | Polio         | Yes No | Urinary Tract   |        |
| Bulimia       | Yes No | Herpes         | Yes No | Prostate      |        | Infections      | Yes No |
| Cancer        | Yes No | High Blood     |        | Problem       | Yes No | Vaginal         |        |
| Cataracts     | Yes No | Pressure       | Yes No | Prosthesis    | Yes No | Infections      | Yes No |
| Chemical      |        | High Blood     |        | Psychiatric   |        | Venereal        |        |
| Dependency    | Yes No | Cholesterol    | Yes No | Care          | Yes No | Disease         | Yes No |
| Chicken Pox   | Yes No | Kidney Disease | Yes No | Rheumatoid    |        | Whooping        |        |
| Depression/   |        | Liver Disease  | Yes No | Arthritis     | Yes No | Cough           | Yes No |
| Anxiety       | Yes No | Measles        | Yes No | Rheumatic     |        | Other _____     |        |
| Diabetes      | Yes No |                |        | Fever         | Yes No | _____           |        |

### EXERCISE

### WORK ACTIVITY

### HABITS

|          |             |                 |                   |
|----------|-------------|-----------------|-------------------|
| None     | Sitting     | Smoking         | Packs/Day _____   |
| Moderate | Standing    | Alcohol         | Drinks/Week _____ |
| Daily    | Light Labor | Coffee/Caffeine | Cups/Day _____    |
| Heavy    | Heavy Labor | Drinks          | Drinks/Day _____  |
|          |             | High Stress     | Reason _____      |
|          |             | Level           |                   |

Are you pregnant? Yes No Due Date \_\_\_\_\_

| Injuries/Surgeries you have had | Description | Date  |
|---------------------------------|-------------|-------|
| Falls                           | _____       | _____ |
| Head Injuries                   | _____       | _____ |
| Broken Bones                    | _____       | _____ |
| Dislocations                    | _____       | _____ |
| Surgeries                       | _____       | _____ |

### FAMILY HISTORY

Have your immediate family members had any of the following:

|                      |                |                           |                      |
|----------------------|----------------|---------------------------|----------------------|
| High Blood Pressure  | HIV Positive   | Back Problems             | Headaches            |
| Heart Disease        | Asthma         | Ulcer or Stomach Problems | Thyroid Disease      |
| Emphysema            | Diabetes       | Stroke                    | Circulation Problems |
| Seizures-Convulsions | Kidney Disease | Arthritis-Rheumatism      | Cancer               |
| Mental Illness       | Osteoporosis   |                           |                      |

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

## ***Oswestry Low Back Disability Index***

### **Section 1 – Pain Intensity**

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

### **Section 2 – Personal Care (washing, dressing, etc.)**

- I can look after myself normally without causing extra pain.
- I can look after myself normally but it causes extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help but manage most of my personal care.
- I need help every day in most aspects of my personal care.
- I need help every day in most aspects of self-care.
- I do not get dressed, wash with difficulty, and stay in bed.

### **Section 3 - Lifting**

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e. on a table).
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

### **Section 4 – Walking**

- Pain does not prevent me walking any distance.
- Pain prevents me walking more than 1 mile.
- Pain prevents me walking more than ¼ of a mile.
- Pain prevents me walking more than 100 yards.
- I can only walk using a stick or crutches.
- I am in bed most of the time and have to crawl to the toilet.

### **Section 5 – Sitting**

- I can sit in any chair as long as I like.
- I can sit in my favorite chair as long as I like.
- Pain prevents me from sitting for more than 1 hour.
- Pain prevents me from sitting for more than ½ hour.
- Pain prevents me from sitting for more than 10 minutes.
- Pain prevents me from sitting at all.

### **Section 6 – Standing**

- I can stand as long as I want without extra pain.
- I can stand as long as I want but it gives me extra pain.
- Pain prevents me from standing more than 1 hour.
- Pain prevents me from standing for more than ½ an hour.
- Pain prevents me from standing for more than 10 minutes.
- Pain prevents me from standing at all.

### **Section 7 – Sleeping**

- My sleep is never disturbed by pain.
- My sleep is occasionally disturbed by pain.
- Because of pain, I have less than 6 hours sleep.
- Because of pain, I have less than 4 hours sleep.
- Because of pain, I have less than 2 hours sleep.
- Pain prevents me from sleeping at all.

### **Section 8 – Sex life (if applicable)**

- My sex life is normal and causes no extra pain.
- My sex life is normal but causes some extra pain.
- My sex life is nearly normal but is very painful.
- My sex life is severely restricted by pain.
- My sex life is nearly absent because of pain.
- Pain prevents any sex life at all.

### **Section 9 – Social Life**

- My social life is normal and cause me no extra pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. sports.
- Pain has restricted my social life and I do not go out as often.
- Pain has restricted social life to my home.
- I have no social life because of pain.

### **Section 10 – Traveling**

- I can travel anywhere without pain.
- I can travel anywhere but it gives extra pain.
- Pain is bad but I manage journeys of over two hours.
- Pain restricts me to short necessary journeys under 30 minutes.
- Pain prevents me from traveling except to receive treatment.

## Neck Disability Index

### Section 1 – Pain Intensity

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

### Section 2 – Personal Care (Washing, Dressing, etc.)

- I can look after myself normally without causing extra pain.
- I can look after myself normally but it causes extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help but manage most of my personal care.
- I need help every day in most aspects of self care.
- I do not get dressed, I wash with difficulty and stay in bed.

### Section 3 – Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift very light weights.
- I cannot lift or carry anything at all.

### Section 4 – Reading

- I can read as much as I want to with no pain in my neck.
- I can read as much as I want to with slight pain in my neck.
- I can read as much as I want with moderate pain in my neck.
- I cannot read as much as I want because of moderate pain in my neck.
- I can hardly read at all because of severe pain in my neck.
- I cannot read at all.

### Section 5 – Headaches

- I have no headaches at all.
- I have slight headaches that come infrequently.
- I have moderate headaches which come infrequently.
- I have moderate headaches which come frequently.
- I have severe headaches which come frequently.
- I have headaches almost all the time.

### Section 6 – Concentration

- I can concentrate fully when I want to with no difficulty.
- I can concentrate fully when I want to with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

### Section 7 – Work

- I can do as much work as I want to.
- I can do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I cannot do any work at all.

### Section 8 – Driving

- I can drive my car without any neck pain.
- I can drive my car as long as I want with slight pain in my neck.
- I can drive my car as long as I want with moderate pain in my neck.
- I cannot drive my car as long as I want because of moderate pain in my neck.
- I can hardly drive at all because of severe pain in my neck.
- I cannot drive my car at all.

### Section 9 – Sleeping

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hour sleepless).
- My sleep is mildly disturbed (1-2 hours sleepless).
- My sleep is moderately disturbed (2-3 hours sleepless).
- My sleep is greatly disturbed (3-5 hours sleepless).
- My sleep is completely disturbed (5-7 hours sleepless).

### Section 10 – Recreation

- I am able to engage in all my recreation activities with no neck pain at all.
- I am able to engage in all my recreation activities, with some pain in my neck.
- I am able to engage in most, but not all, of my usual recreation activities because of pain in my neck.
- I am able to engage in a few of my usual recreation activities because of pain in my neck.
- I can hardly do any recreation activities because of pain in my neck.
- I cannot do any recreation activities at all.

|       |                     |
|-------|---------------------|
| 0-4   | No disability       |
| 5-14  | Mild disability     |
| 15-24 | Moderate disability |
| 25-34 | Severe disability   |
| > 35  | Complete disability |

# **Blando Chiropractic**

## **FINANCIAL POLICY**

**Our recommendations are based on a desire to see you get well and stay well. Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. Regardless of your coverage, we'll suggest the chiropractic care we think you need. We ask that you read and understand our policy as it applies to your particular situation.**

### **INSURANCE FORMS/PAYMENT**

If you receive any correspondence from your insurance carrier pertaining to the care you have received at this office or a request for more information regarding your care, please bring it in as soon as possible. It is very important that we keep your file as up to date as possible. Occasionally, either by mistake, or due to provisions in your policy, the check issued by the insurance company for payment of services rendered in our office, may come to you instead of our office. If you should receive any unexpected check in the mail, please contact us to see if it does represent payment of your bill here.

### **PATIENTS WITHOUT INSURANCE**

We request that 100% of the first visit be paid at the time of the visit. On other visits, payment may be made at the end of the week if you sign a credit guarantee form. We are happy to accept your check, Discover, Master Card or Visa.

### **GROUP OR INDIVIDUAL INSURANCE**

Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain if your insurance covers Chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. When possible, we will call to verify benefits on your insurance; however, the benefits quoted to us by your insurance company are not a guarantee of payment. As a courtesy to you, our office will complete any necessary insurance forms at no additional charge, and file them with your insurance company to help you collect. It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment of any non-covered services, deductibles or co-pays. You may also pay the full amount due each day thereby qualifying for our Time of Service Reduction in fees. You may then submit the bill to your insurance carrier for reimbursement.

### **“ON THE JOB” INJURY (Worker’s Compensation) and PERSONAL INJURY OR AUTOMOBILE ACCIDENTS**

We no longer accept these insurance coverages.

### **MEDICARE**

We do accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover which for Chiropractors is ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20%. All other services we provide are NON-COVERED. These services include, but are not limited to, examinations, therapies, orthotics, supports, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Secondary insurance may or may not pay for these non-covered services. Our office completes and files the forms for Medicare at no charge.

### **SECONDARY INSURANCE**

Please inform us of any secondary insurance you may have. We will assist you if you need help in filing.

### **FLEX PLANS/MEDICAL SAVINGS ACCOUNTS**

Please inform us if you have a medical savings account, sometimes known as a 'flex plan'. We will be happy to provide you with a statement of your charges for reimbursement.

- I have read and understand the payment policy of Blando Chiropractic. I understand that my insurance is an arrangement between myself and my insurance company, **NOT** between Blando Chiropractic and my insurance company. I request that Blando Chiropractic prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, or if I suspend or

terminate my schedule of care as prescribed by the doctors at Blando Chiropractic that fees will be due and payable immediately.

- Authorization:** I, with my signature, authorize Blando Chiropractic to provide medical care for me, or to this patient for which I am the legal guardian.
  - I also authorize Blando Chiropractic, to furnish information to the identified insurance carrier(s) for prior authorization, pre-certification, or payment of health care services. This information may include claims, copies of medical information, faxes, and phone calls concerning care provided or proposed. I shall assign all payment for these services to Blando Chiropractic, realizing I am personally responsible for the charges incurred, including items determined to be non-covered.
  - I also acknowledge that I have been given or have been offered a copy of the "Practice's" privacy policy as required by law. I request the following restrictions be placed on the "Practice's" use and/or disclosure of my health information (leave blank if NO).
- 

- The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.
- The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

\_\_\_\_\_  
**Patient/Guardian Signature**

\_\_\_\_\_  
**Date**

### INFORMED CONSENT

PATIENT NAME \_\_\_\_\_

Clinic Name: Blando Chiropractic

Doctor's Name: Jonathan Blando D.C.

Address: 26 Kellogg Rd., New Hartford, NY 13413

Phone: 315-765-0478 Fax: 315-765-0478

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or Spinal Adjustment" As the joints in your spine are moved, you may experience a "pop" as part of the process. I will also use modalities such as moist heat and electrical stimulation machines.

There are certain complications that can occur as a result of a spinal manipulation, heat and electrical stimulation. These complications include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathetic palsy), costovertebral strains and separation, burns and skin irritation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take your clinical history.

DATE \_\_\_\_\_

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

\_\_\_\_\_  
Signature of Parent or Guardian (if a minor)

\_\_\_\_\_  
Signature

# Late/Cancellation/Missed Appointment Policy

Our goal is to provide quality medical care in a timely manner. In order to do so, we have had to implement an appointment/cancellation policy. This policy enables us to better utilize available appointments for our patients in severe pain needing immediate care.

## Cancellation of an Appointment:

In order to be respectful of the medical needs of other patients, please be courteous and call the office promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Calling early in the day is appreciated. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

## How to Cancel Your Appointment:

To cancel appointments, please call 315-765-0478. If you do not reach the receptionist you may leave a detailed message on the voice mail. If you would like to reschedule your appointment, please be sure to leave us your phone number and let us know the best time to return your call.

## No-Show Policy:

A "no-show" is someone who misses an appointment without calling 24 hours in advance to cancel. "No-shows" inconvenience those individuals who need access to medical care in a timely manner, as well as the physician. A failure to show up at the time of a scheduled appointment will be recorded in the patient's chart as a "no-show". The first time there is a "no-show" there will be no charge to the patient. Any additional "no-shows" will result in a fee of \$25.00 for regular appointments and \$50.00 for procedures. A credit card authorization form or \$50 deposit will also be required prior to future appointments. If a patient accumulates 3 "No-shows", he or she may be asked to leave the practice.

## Cash Only:

If you are uncomfortable using a credit card, following your first "no-show" a \$25.00 cash deposit will be required to schedule future appointments. This amount will be applied to your bill on the day of the appointment and any remaining balance will be refunded at this time. No checks.

## Late Cancellations:

Late cancellations will be considered as a "no-show". Exceptions will only be made in extraordinary circumstances. Cancellations made more than 24 hours in advance of your scheduled appointment time will not be assessed a cancellation fee.

## Late to Appointment:

If you are more than 10 minutes late without notice, you will be charged the "no-show" fee of \$25 in addition to your bill. This charge will be applied even if you show to your appointment. This charge is applied because you are inconveniencing other patients that have scheduled appointments and causing the doctor to run behind.

I understand this policy and the charges will be in addition to my normal bill and that these charges are not covered under my health insurance.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

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