New Patient Registration Form

PLEASE PRINT **DATE**_____

How did you learn about our practice? Physician _____

Relative_____ Friend_____ Website_____ Phone book_____ Newspaper_____ Other _____

Patient's Full Name _____ Age _____

Home Address _____

City _____ **State** ___ **Zip** _____

Home Phone Number _____ Mobile Phone Number _____

Emergency Contact Person _____ Emergency Phone Number _____

Patient's Email Address _____

Patient's Date of Birth _____ **Social Security Number** _____

Sex M ___ F ____

Marital Status (circle one) Single Married Widowed Divorced

Race (optional) Caucasian __ Hispanic __ African American __ Asian__ Other__

Patient's Employer _____

If not employed, is patient… Retired? __ Student? __ Homemaker? __ Unemployed? __

Patient Employer Address _____

City _____ State _____ Zip _____

Employer Phone Number _____ Extension _____

St Luke's PHYSICIAN GROUP

New Patient Registration Form

Responsible Party Information

Who is financially responsible for the account? (Note: The responsible party can never be a child.)

Is the Responsible Party the same as the patient information? Yes___ No__ (if no, please fill in the information below)

Name _____

Address _____ **City** _____ **State** ___ **Zip** ____

Phone Number _____

Email Address _____

If patient is a MINOR, fill in responsible parent or guardian:

Patient/Guardian Name _____

Patient/Guardian Address _____ City _____ State ____ Zip ____

Patient/Guardian Phone Number _____

Patient/Guardian Email Address _____

I acknowledge the above information is correct and I accept financial responsibility for any services offered for my dependent or myself.

Signature _____ **Date** _____

St Luke's PHYSICIAN GROUP

New Patient Registration Form

Primary Insurance Information

Name of Primary Insurance _____

Primary Insurance Address _____

City _____ **State** ____ **Zip** _____

Insurance Phone Number _____

Policy Number _____ Group # _____

Is the Patient the subscriber for the Primary Insurance? Yes ___ No ___
(If no, please complete this section.)

Subscriber Relationship to Patient (circle one) SELF SPOUSE CHILD OTHER _____
Subscriber Name _____
Subscriber Address _____
Subscriber City _____ **State** _____ **Zip** _____
Subscriber Date of Birth _____ **Sex** M ___ F ___
Subscriber Social Security Number _____**Subscriber Phone**_____
Subscriber Employer _____
Subscriber Employer Address _____
City _____ State _____ Zip _____
Subscriber Employer Phone _____

Secondary Insurance Information (if applicable)

Name of Secondary Insurance _____

Secondary Insurance Address _____

City _____ **State** ____ **Zip** _____

Insurance Phone Number _____
Policy Number _____ Group # _____

Subscriber Relationship to Patient (circle one) SELF SPOUSE CHILD OTHER _____
Subscriber Name _____
Subscriber Address _____
Subscriber City _____ **State** _____ **Zip** _____
Subscriber Date of Birth _____ **Sex** M F
Subscriber Social Security Number _____ **Subscriber Phone**_____
Subscriber Employer _____
Subscriber Employer Address _____
City _____ State _____ Zip _____
Subscriber Employer Phone _____

St Luke's PHYSICIAN GROUP

New Patient Registration Form

Tertiary Insurance Information (if applicable)

Name of Tertiary Insurance _____

Tertiary Insurance Address _____

City _____ **State** ____ **Zip** _____

Insurance Phone Number _____

Policy Number _____ Group # _____

Subscriber Relationship to Patient (circle one) SELF SPOUSE CHILD OTHER _____
Subscriber Name _____
Subscriber Address _____
Subscriber City _____ **State** _____ **Zip** _____
Subscriber Date of Birth _____ **Sex** M F
Subscriber Social Security Number _____ **Subscriber Phone**_____
Subscriber Employer _____
Subscriber Employer Address _____
City _____ State _____ Zip _____
Subscriber Employer Phone _____

St Luke's PHYSICIAN GROUP

BP: _____
HT: _____
WT: _____
Pulse: _____
Initials: _____

Orthopaedic Specialists

Patient Information and Medical History

Patient Name: _____ Date: _____

Family Physician: _____ Phone #: _____

My Problem is: ____ Work Related ____ Accident Related ____ Other: _____

My specific orthopaedic complaint is: _____

Body Area (specify Right or Left): _____

Description of problem/accident including duration:

_____

Date of accident: _____

Were you treated by any other physician for this problem: ____ Yes ____ No

If yes, name of physician: _____ Phone Number: _____

Treatment: _____

Symptoms: ___ pain ___ swelling ___ weakness ___ instability ___ other: _____

Past Tests: ___ x-ray ___ MRI ___ CT Scan ___ None ___ Other _____

Tests were performed at _____

Please list <u>all active medications</u> you currently take and the medical reason for taking the medication

MEDICATION / REASON	MEDICATION / REASON
1. _____ / _____	5. _____ / _____
2. _____ / _____	6. _____ / _____
3. _____ / _____	7. _____ / _____
4. _____ / _____	8. _____ / _____

☐ See attached list of medications

Are you allergic to any medications: _____ ☐ No Allergies

<u>List past surgeries and the year they occurred:</u> ☐ No Past Surgeries

1. _____	4. _____
2. _____	5. _____
3. _____	6. _____

(Please complete other side)

Do you have a history of any of the following medical conditions (please check yes or no):

High Blood Pressure □ yes □ no Diabetes □ yes □ no Thyroid Disease □ yes □ no

Stroke □ yes □ no Liver Disease □ yes □ no Bleeding Disorder □ yes □ no

Heart Disorder □ yes □ no Depression □ yes □ no Asthma/COPD □ yes □ no

Seizures □ yes □ no Stomach Problems □ yes □ no Cancer □ yes □ no

Kidney Disease □ yes □ no Skin Disorders □ yes □ no Arthritis □ yes □ no

Are you: _____ Right handed _____ Left handed

Females: Date of last menstrual period _____ Date of last PAP smear _____

□ History of Abnormal PAP Smear

Males: Date of last rectal exam _____ □ History of Prostate Problems

Are you currently experiencing any of the following (please circle all that apply or circle no symptoms):

Fever – Chills – Weight loss – Night Sweats – No Symptoms

Chest Pain– Palpitations – No Cardiovascular Symptoms

Bronchitis – Asthma – Shortness of Breath – Cough – No Respiratory Symptoms

Heartburn – Jaundice – Nausea – Diarrhea – Constipation – No GI Symptoms

Urinary Infection – Blood in Urine – Incontinence – No Urinary Symptoms

Yeast Infection – Breast Lumps – Nipple Discharge – No Symptoms

Joint Pain – Stiffness – Swelling – No other Musculoskeletal Symptoms

Rashes – Mole Changes – No Skin Symptoms

Seizures – Numbness – Weakness – Dizziness – No Neurological Symptoms

Frequent Urination – Excessive Thirst – No Symptoms

Depression – Hallucinations – No Psychiatric Symptoms

Personal Habits

Do you smoke? _____ Yes _____ No

If yes: ____ cigarettes ____ cigars ____ pipe How many per day? _____ For how long? _____

Do you drink? (check all that apply)

Alcohol _____ How often? _____ Type _____

Coffee _____ Regular or Decaf _____ How many cups per day? _____

Tea _____ Regular or Decaf _____ How many cups per day? _____

Cola _____ Regular or Decaf _____ How many cups per day? _____

Family History – Do you have any family members that have now or have had:

Cancer _____ Yes _____ No If yes, what type _____

Arthritis _____ Yes _____ No Osteoperosis _____ Yes _____ No

Other Musculoskeletal problems _____ Yes _____ No If yes – type of problem _____

Reviewed by: _____ **Date** _____

St Luke's
PHYSICIAN GROUP

FINANCIAL POLICY

It is the policy of this practice as a member of St. Luke's Physician Group, to have a Financial Policy that clearly outlines patient and practice responsibilities. We are committed to providing our patients with the best possible medical care while minimizing administrative costs. This Policy has been developed with these objectives in mind, and to avoid any misunderstandings or disagreements concerning payment for professional services.

Please read the following carefully:

For patients who do not have insurance:

- Patients who do not have any insurance coverage are expected to pay for services rendered at the time of the visit. Financial assistance may be available for qualified patients. If a patient feels that he or she may qualify for assistance, the practice receptionist should be notified at the appointment check in.
- Payment plans are available for patients who meet the minimum requirements.

For patients who are currently covered by insurance:

- The patient is responsible to provide us with valid health insurance information, and should bring their insurance card to each visit.
- Our office participates with numerous insurance companies and managed health care programs. For patients that are members of one of these plans, our business office will submit a claim for services using a standard CMS 1500 claim form.
- St. Luke's Physician Group bills secondary insurances as a courtesy to our patients.

If you have a plan that our practice participates with:

- The patient is responsible to pay any co-payment or any portion of the charges as specified by the plan at the time of the visit
- Any medical services not covered by an individual's insurance plan are the patient's responsibility and payment in full is due at the time of the visit. Specific coverage issues should be addressed by the insurance company's member services department (telephone number is on the insurance card).

If you have a plan that our office <u>does not</u> participate with:

- If a patient has insurance that we <u>do not participate in,</u> our office will file a claim upon request, but ***<u>payment is expected at time of service.</u>***

If you are covered by an HMO or Managed Care Plan:

- The patient is responsible to pay any co-payment or any portion of the charges as specified by the plan at the time of the visit.
- The patient is responsible to ensure that any required referrals for treatment are provided to the practice **at the time of visit.** Non-emergent visits may be rescheduled, or the patient may be financially responsible due to the lack of the referral.

Other:

- The office reserves the right to charge for the completion of forms. For example, insurance, disability or medication programs, and the copying of medical records.
- Any outstanding patient balance that is either not paid in full or under a payment plan agreement will be transferred to an outside collection agency.

St Luke's
PHYSICIAN GROUP

NOTICE OF FINANCIAL POLICY ACKNOWLEDGEMENT

I HAVE RECEIVED A COPY OF ST. LUKE'S PHYSICIAN GROUP NOTICE OF FINANCIAL POLICIES AND PROCEDURES

*SIGNATURE*_____

PRINT NAME_____

DATE_____

St Luke's PHYSICIAN GROUP

Financial Liability Acknowledgement Form

Member's Name: _____ Date: _____

Insurance Company: _____ Provider Name: _____

Member ID #: _____ Group/Provider ID#: _____

We expect that the insurance company listed above will not pay for the services described below:

_____

_____

You may be responsible for the above listed service(s) due to the following reason(s):
(Check all that apply)

- ☐ Insurance does not pay for the services rendered; for example non-covered services, such as preventative care, physicals or flu shots. Please see your Member Handbook/Evidence of Coverage for a complete listing of the non-covered services.
- ☐ Services are not covered without a Referral from your Primary Care / OB-GYN / Specialist Physician.
- ☐ Services are not covered without prior Authorization/Pre-Certification by your Insurance Plan.
- ☐ Service has been determined to be not medically necessary by your Insurance Plan.
- ☐ Insurance does not pay for this service because it is considered investigational.
- ☐ Insurance does not pay for this type of service unless it was due to an emergency.
- ☐ Our office does not contract with your insurance company and you are considered Out-Of-Network.
- ☐ Other: _____
  _____

The provider identified above has notified me that the requested service(s) is non-covered for the reason(s) stated above. I understand that I am fully responsible for payment of the services listed above. Payment is required at time of service unless prior arrangements have been made and agreed upon by the Manager and/or Central Business Office.

_____ _____
(Member Signature) Date:

_____ _____
(Witness Name) (Witness Signature)

In the event that the patient is a minor, the undersigned parent/guardian of that minor, agrees to be financially responsible for the services described above.

_____ _____
(Parent/Guardian Signature) Date:

_____ _____
(Witness Name) (Witness Signature)

St Luke's PHYSICIAN GROUP

INSURANCE AUTHORIZATION FORM

PATIENT ACCOUNT NUMBER PATIENT NAME

_____MEDICARE HIC NUMBER_____

Statement to Permit Payment of Medicare Benefits to Provider, Physician's and Patient

I request payment of authorized Medicare Benefits to me or in my behalf for any services furnished to me by St. Luke's Health Services. I authorize any holder of medical and other information about me to release to the Health Care Financing Administration (Medicare) and its agents any information needed to determine benefits or benefits for related services. I understand that I am responsible for any health insurance deductibles, co-insurances or other non-covered services.

_____ _____

Date Signature- Beneficiary

_____ _____

Date Other Signature

_____

Relationship and Reason

_____MEDIGAP HIC NUMBER_____

MEDIGAP POLICY NUMBER_____

I request that payment of authorized Medigap benefits be made either to me or on my behalf to the provider of service and (or) supplier for any services furnished to me by that provider of service and (or) supplier. I authorize any holder of Medicare information about me to release to _____any information needed to determine these benefits payable for related services. (Name of Medigap Insurer)

_____ _____

Date Signature- Beneficiary

_____ _____

Date Other Signature

_____

Relationship and Reason

_____MEDICAL ASSISTANCE RECIPIENT NUMBER_____

"My signature certifies that I received a service or item on the date listed below. I understand that payment for services or items will be from Federal and State Funds, and that any false claims, statements or documents, or concealment of material may be prosecuted under applicable Federal and State Laws.

I have read and agree with the above statement."

_____ _____

Date Signature

_____WORKER'S COMPENSATION _____AUTO _____COMMERCIAL

Authorization to Release Medical Information- "I authorize St. Luke's Health Services to release any information required to complete my compensation, auto and/or insurance claim to my employer/insurance company pertaining to my visit(s) of _____.

_____ _____

Date Signature

Assignment of Insurance Benefits- "I hereby assign to St. Luke's Health Services (SLHS) and authorize and direct that payment be made directly to SLHS, of all benefits otherwise payable to me directly under the terms of my insurance policies (including major medical) by reason of the services described in the statements rendered by SLHS; provide that SLHS shall refund to the persons or persons entitled to receive the same, any payments in excess of its full charges. I understand that I am financially responsible for all charges not covered by this assignment"

_____ _____

Date Signature

ST. LUKE'S HOSPITAL & HEALTH NETWORK
NOTICE OF PRIVACY PRACTICES

I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

II. WE HAVE A LEGAL DUTY TO SAFEGAURD YOUR PROTECTED HEALTH INFORMATION (PHI)

We are legally required to protect the privacy of your health information. We call this information protected health information, or PHI for short, and it includes information that can be used to identify you, that we've created or received about your past, present, or future health condition, the provision of health care to you, or the payment of this health care. We must provide you with this notice about our privacy practices that explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish this purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice.

However, we reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. Before we make an important change to out policies, we will promptly change this notice and post a new notice in the appropriate areas. You can also request a copy of this notice from the contact person listed in Section VI below at any time and can view a copy of the notice on our web site at http://www.slhhn.org.

III. HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

We use and disclose health information for many different reasons. For some of these uses or disclosures, we need your prior consent or specific authorization. Below, we describe the different categories of our uses and disclosures and give you some examples of each category.

A. Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations.

We may use and disclose your PHI for the following reasons:

1. **For Treatment.** We may disclose your PHI to physicians, nurses, medical students, and other health care personnel who provide you with health care services or are involved in your care. For example, if you're being treated for a knee injury, we may disclose your PHI to the physical rehabilitation department in order to coordinate your care.
2. **To Obtain Payment for Treatment.** We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided for you. For example, we may provide portions of your PHI to our billing department and your health plan to get paid for the health care services we provided to you. We may also provide your PHI to our business associates, such as billing companies, claims processing companies, and others that process out health care claim.
3. **For Health Care Operations.** We may disclose your PHI in order to operate this provider. For example, we may use your PHI in order to evaluate the quality of health care services that you received or evaluate the performance of the health care professionals who provided health care services to you. We may also provide your PHI to our accountants, attorneys, consultants, and others in order to make sure we're complying with the laws that affect us.

B. Certain Uses and Disclosures Do Not Require Your Consent. We may use and disclose your PHI without your consent or authorization for the following reasons:

1. **When a Disclosure is Required by Federal, State, or Local Law, Judicial or Administrative Proceedings, or Law Enforcement.** For example, we make disclosures when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence; when dealing with gunshot or other wounds; or when ordered in judicial or administrative proceedings.
2. **For Public Health Activities.** For example, we report information about births, deaths, and various diseases, to government officials in charge of collecting that information, and we provide coroners, medical examiners, and funeral directors necessary information relating to an individual's death.
3. **For Health Oversight Activities.** For example, we will provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.
4. **For Purposes of Organ Donation.** We may notify organ procurement organizations to assist them in organ, eye, or tissue donation and transplants.
5. **For Research Purposes.** In certain circumstances, we may provide PHI in order to conduct medical research.
6. **To Avoid Harm.** In order to avoid serious threat to health or safety of a person or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lesson such harm.
7. **For Specific Government Functions.** We may disclose PHI of military personnel and veterans in certain situations. And we may disclose PHI for national security purposes, such as protecting the President of the United States or conducting intelligence operations.
8. **For Workers' Compensation Purposes.** We may provide PHI in order to comply with workers' compensation laws.
9. **Appointment Reminders and Health-Related Benefits or Service.** We may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits we offer.
10. **Fundraising Activities.** We may use PHI to raise funds for our organizations. The money raised through these activities is used to expand and support the health care services and educational programs we provide to the community. If you do not wish to be contacted as part of our fundraising efforts, please contact the person listed in Section VI below.

C. Two Uses and Disclosures Require You to Have the Opportunity to Object.

1. **Patient Directories.** We may include your name, location in this facility, general condition, and religious affiliation, in our patient directory for use by clergy and visitors who ask for you by name, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.
2. **Disclosures to Family, Friends, or Others.** We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

D. All Other Uses and Disclosures Require Your Prior Written Authorization.

In any other situation not described in sections IIIA, B, and C above, we will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke that authorization in writing to stop any future uses and disclosures (to the extent that we haven't taken any action relying on the authorization).

IV. WHAT RIGHT YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

A. The Right to Request Limits on Uses and Disclosures of your PHI. You have the right to ask that we limit how we use and disclose your PHI. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.

B. The Right to Choose How We Send PHI to You. You have the right to ask that we send information to you to an alternate address (*for example, sending information to your work address rather than your home address*) or by alternate means (*for example, e-mail instead of regular mail).* We must agree to your request so long as we can easily provide it in the format you requested.

C. The Right to See and Get Copies of Your PHI. In most cases, you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. If we don't have your PHI but we know who does, we will tell you how to get it. We will respond to you within thirty days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed. **If you request copies of your PHI, there will be a charge based on state and federal regulations.**

D. The Right to Get a List of the Disclosures We Have Made. You have the right to get a list of whom we have released your PHI. The list will not include uses or disclosures that you have already consented to, such as those made for treatment, payment, or healthcare operations, directly to you, to your family, or in our facility directory. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or before April 14, 2003.

We will respond within sixty days of receiving your request. The list we will give you will include releases made up to the last six years. The list will include the date of the release, to which PHI was released (including their address, if known), a description of the information released, and the reason for the release. We will provide the list to you at no charge, but if you make more than one request in the same year, we will charge you in accordance with the state and federal regulations.

E. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PhI or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. We will respond within six days of receiving your request. We may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, or (iv) not part of our records. Out written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you do not request a statement of disagreement, you have the right to request that your request and our denial be attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change to your PHI.

F. The Right to Get This Notice by E-Mail. You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of this notice.

V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201. We will take no retaliatory action against you if you file a complaint about our privacy practices.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THTIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you have any questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact

Chief Compliance & Privacy Officer
St. Luke's Hospital & Health Network
801 Ostrum Street
Bethlehem, PA 18015
484-526-3100

VII. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on April 14, 2003.

St Luke's PHYSICIAN GROUP

Release of Health Information

I, _____, hereby authorize

_____ to disclose the following information from the health records of:

Patient Name:_____

Date of Birth: _____

Address: _____

_____

_____

Covering the period(s) of health care:

From: _____to _____

The information to be disclosed:

- ☐ **Complete Health Record**
- ☐ Inpatient Records
- ☐ History and Physical Examination/ Progress Reports
- ☐ Consultation Report
- ☐ Operative Reports
- ☐ Laboratory/X-ray Reports

I understand that this will include information relating to (check if applicable):

- ☐ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus)
- ☐ Psychiatric care
- ☐ Treatment for alcohol and/or drug abuse

This information is to be disclosed for the purpose of _____
and is to be sent to: _____
_____
_____.

I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance upon this authorization. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____ _____

Signature of Patient or Legal Guardian Date

COMMUNICATION CONSENT
St. Luke's Orthopaedic Specialists

Patient Name_____ DOB:_____

It is the office policy of the St. Luke's Orthopaedic Specialists and staff not to release confidential and/or unauthorized information on a home telephone, answering machine, work telephone, voice mail, or cell phone. Whenever calling your residence, we will not leave a message if the recorded message does not identify your name or phone number. Information will also not be left with an unauthorized person who may answer the phone.

I authorize the staff of St. Luke's Orthopaedic Specialists to leave medical information pertaining to my care by the following methods and will assume the responsibility to notify the office whenever the information changes.

Please complete the following and include phone numbers:

Home Phone/Answering Machine#_____ _____**yes** _____**no**

Work Telephone/Voicemail #_____ _____**yes** _____**no**

Cell Phone/Voicemail # _____ _____**yes** _____**no**

The following authorizes us to release medical information to someone other than you.

Spouse **Name**_____ _____**yes** _____**no**

Parent/Guardian **Name**_____ _____**yes** _____**no**

Other-Please list relationship:

_____ _____**yes** _____**no**

_____ _____**yes** _____**no**

Patient Signature _____ Date_____
(Parent/Guardian if minor)

Patient Name(Print)_____