

**Comprehensive Health and Chiropractic Centre
Family Practice**

555 South Rancho Santa Fe Road, Ste. 200
San Marcos, CA 92069

(760) 736-0286 • (760) 736-3113



PERSONAL DATA	<p>Date: _____ Chart Number: _____</p> <p>Home phone: _____ Cell phone: _____</p> <p>Last Name: _____ First Name: _____ M.I. _____</p> <p>Address: _____</p> <p>City: _____ State: _____ Zip: _____</p> <p>Birthdate: _____ Age: _____ Sex: M F Height: _____ Weight: _____</p> <p>Please check one: <input type="checkbox"/> Minor <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed</p> <p>SSN: _____ / _____ / _____ Your Driver's Lic.#: _____</p> <p>Are you/have you been disabled from work? _____</p> <p>E-mail address: _____</p> <p>We call you before your appointment to remind you of the appointment. Would you like to be reminded by: 1) Telephone; 2) Email; or 3) Both (please circle your choice)</p> <p>Would you like to receive our newsletter by email? 1) Yes; 2) No (please circle your choice)</p>
BUSINESS DATA	<p>Business phone: _____</p> <p>Business/Employer: _____</p> <p>Type of work: _____</p> <p>Address: _____</p> <p>City: _____ State: _____ Zip: _____</p>
SPOUSE DATA	<p>Spouse's name: _____ Social Security # _____</p> <p>Business phone: _____</p> <p>Business/Employer: _____</p> <p>Type of work: _____</p> <p>Address: _____</p> <p>City: _____ State: _____ Zip: _____</p>
EMERGENCY CONTACT	<p>Name and address of nearest relative not living with you:</p> <p>Name: _____ Relationship: _____</p> <p>Address: _____ Phone#: _____</p>
REFERRAL	<p>Referred to this office by: _____</p>

Comprehensive Health and Chiropractic Centre

Dr. Russell Revilla

INSURANCE



RESPONSIBLE PARTY

Name of person responsible for this account? _____
Relationship to patient _____
Address _____ City _____ State _____ Zip _____
Name of Employer _____ Work phone# _____



INSURANCE INFORMATION

Name of Insured _____ Relationship to patient _____
Birth Date _____ SS# _____ Date employed _____
Address _____ City _____ State _____ Zip _____
Insurance Co. _____ Phone# () _____ - _____
Insurance Address _____ City _____ State _____ Zip _____
Group# _____ ID# _____
How much is your deductible? _____ How much have you met? _____
Maximum annual benefit? _____



Do you have additional Insurance? NO _____ YES _____

Address _____ City _____ State _____ Zip _____
Insurance Co. _____ Phone# () _____ - _____
Insurance Address _____ City _____ State _____ Zip _____
Group# _____ Employer# _____
How much is your deductible? _____ How much have you met? _____
Maximum annual benefit? _____



PATIENT AGREEMENT

As a courtesy to our patients, Comprehensive Health and Chiropractic Centre is set up to utilize direct payment from insurance companies. However, it is important to understand that your health and accident insurance policy is an arrangement between you and your insurance company. You are personally responsible for all service charges incurred in our office. Until your insurance coverage has been verified, we expect payment in full when the services are rendered.

We ask that you keep our deductible charges current. After your deductible has been met, we request that you continue to keep your portion of your claim up to date. You are required to sign an "authorization and assignment of benefits" from and any other documents required by your insurance company on your first office visit. You are responsible for providing this office with insurance information and claim forms. You will be considered a cash-paying patient until this information is received. Our office does not guarantee that your insurance will pay. Regardless of what type of insurance you have, you are ultimately responsible for your account. Most insurance companies do not cover the cost of vitamin supplements and orthopedic supplies. Therefore, these costs are the responsibility of the patient. Payment must be made upon receipt of supplies.

_____/_____/_____
Patient Signature Date



AUTHORIZATION TO RELEASE INFORMATION

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you, and hereby release you of any consequence thereof.

I understand that in the case of default on my part, that necessitates Comprehensive Health and Chiropractic Centre or its agents to employ legal and/or collection counsel, I am responsible for collection charges incurred. These charges will be added to my bill.

Should I be unable to meet the terms of this agreement at anytime, I agree to notify the office immediately.

_____/_____/_____
Patient Signature Date

_____/_____/_____
Staff Signature Date



CURRENT HEALTH CONDITION

Primary Unwanted Health Condition _____

2nd Unwanted Health Condition _____

3rd Unwanted Health Condition _____

4th Unwanted Health Condition _____

Other Doctors Seen For This Condition: Yes No Who? _____

Type of Treatment: _____ Results: _____

When Did This Condition Begin? _____ Has This Condition Occurred Before? Yes No

Is Condition: Job Related Auto Accident Home Injury Fall Other: _____

Date of Accident: _____

Time of Accident: _____

Have You Made A Report of Your Accident To Your Employer: Yes No

Drugs You Now Take: Nerve Pills Pain Killers/Muscle Relaxers Blood Pressure Medicine

Insulin Other _____

Do You Wear A Shoe Lift? Yes No

Check any of the conditions ***in Section 2*** that you have had the past 6 months:

PREVIOUS CONDITIONS



NERVOUS SYSTEM CODE

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Stress

GENERAL CODE

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- Headaches

GASTRO-INTESTINAL CODE

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps
- Gas/Bloating After Meals
- Heartburn
- Black/Bloody Stool
- Colitis

GENITO-URINARY CODE

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine

C-V-R CODE

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat

C-V-R CODE (cont.)

- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

EENT CODE

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Stuffed Nose

MALE/FEMALE CODE

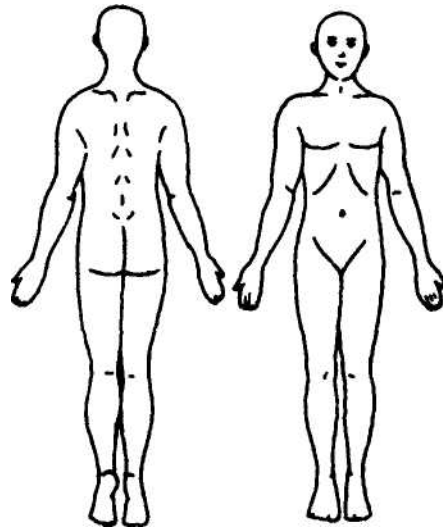
- Menstrual Irregularity
- Menstrual Cramps
- Vaginal Pain/Infection
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction
- Other Problems
- _____
- _____
- _____

FEMALES ONLY:

When was your last period? _____

Are you pregnant?

- Yes No Not Sure



Please outline on the diagram the area(s) of your discomfort



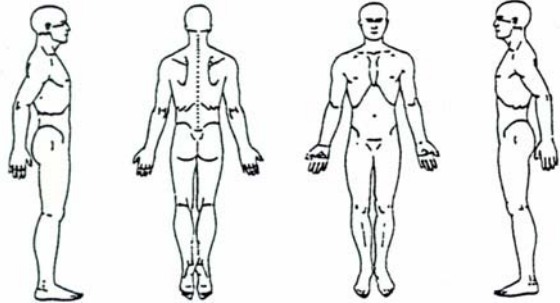
MUSCULO-SKELETAL (neck, back, leg, etc.) {fill out next four pages as needed}

#1

PAIN COMPLAINT:

[Empty box for patient name]

- 1. When did your symptoms appear? Date of onset: Was it: Sudden Gradual
2. Is this condition getting progressively worse? Yes No Unknown
3. Describe your pain/complaint: Dull Sharp Ache Stabbing Deep Superficial Spasm/tension Numbness Tingling Burning Stiffness Pulling
4. Radiation: Does the pain go to other parts of the body? Yes No Where?
5. Degree: What is the degree of your pain? Mild Moderate Severe
6. Frequency: How often do you have this pain? Occasional Intermittent Frequent Constant
7. Duration: How long does the pain last? Min. Hrs. Days
8. What makes the pain worse? Standing Sitting Bending Twisting Walking Lifting Sleeping Heat Cold Stoopng Sex Other
9. What makes the pain better? Sitting Standing Rest Heat Cold Aspirin/medication Other
10. Does it interfere with your : Work Sleep Daily routine Recreation
11. What treatment have you already received for this condition? Medications Surgery Physical therapy Chiropractic services None Other



Draw/Shade the affected areas on the image(s) above to indicate your pain locations. Please use arrows to show the direction that the pain flows to or from these areas.

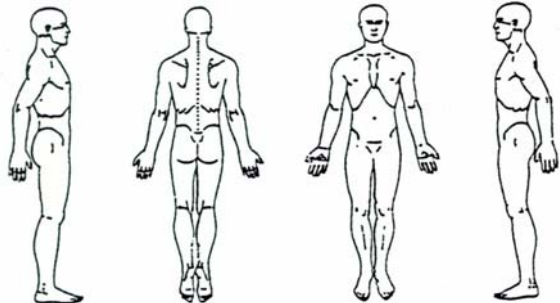
Please RATE YOUR PAIN! Please circle the accurate pain level below (1-low; 10-high) 1 2 3 4 5 6 7 8 9 10

#2

PAIN COMPLAINT:

[Empty box for patient name]

- 1. When did your symptoms appear? Date of onset: Was it: Sudden Gradual
2. Is this condition getting progressively worse? Yes No Unknown
3. Describe your pain/complaint: Dull Sharp Ache Stabbing Deep Superficial Spasm/tension Numbness Tingling Burning Stiffness Pulling
4. Radiation: Does the pain go to other parts of the body? Yes No Where?
5. Degree: What is the degree of your pain? Mild Moderate Severe
6. Frequency: How often do you have this pain? Occasional Intermittent Frequent Constant
7. Duration: How long does the pain last? Min. Hrs. Days
8. What makes the pain worse? Standing Sitting Bending Twisting Walking Lifting Sleeping Heat Cold Stoopng Sex Other
9. What makes the pain better? Sitting Standing Rest Heat Cold Aspirin/medication Other
10. Does it interfere with your : Work Sleep Daily routine Recreation
11. What treatment have you already received for this condition? Medications Surgery Physical therapy Chiropractic services None Other



Draw/Shade the affected areas on the image(s) above to indicate your pain locations. Please use arrows to show the direction that the pain flows to or from these areas.

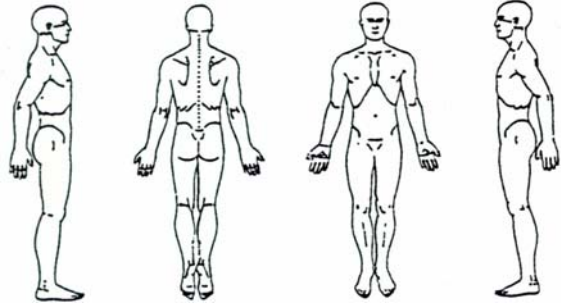
Please RATE YOUR PAIN! Please circle the accurate pain level below (1-low; 10-high) 1 2 3 4 5 6 7 8 9 10



MUSCULO-SKELETAL (neck, back, leg, etc.) {fill out next four pages as needed}

#3 PAIN COMPLAINT: []

- 1. When did your symptoms appear? Date of onset: _____ Was it: Sudden Gradual
2. Is this condition getting progressively worse? Yes No Unknown
3. Describe your pain/complaint:
 Dull Sharp Ache Stabbing
 Deep Superficial Spasm/tension Numbness
 Tingling Burning Stiffness Pulling
4. Radiation: Does the pain go to other parts of the body?
 Yes No Where? _____
5. Degree: What is the degree of your pain?
 Mild Moderate Severe
6. Frequency: How often do you have this pain?
 Occasional Intermittent Frequent Constant
7. Duration: How long does the pain last? ___Min. ___Hrs. ___Days
8. What makes the pain worse?
 Standing Sitting Bending Twisting
 Walking Lifting Sleeping Heat
 Cold Stooping Sex Other
9. What makes the pain better?
 Sitting Standing Rest Heat Cold
 Aspirin/medication Other _____
10. Does it interfere with your :
 Work Sleep Daily routine Recreation
11. What treatment have you already received for this condition?
 Medications Surgery Physical therapy Chiropractic services None Other _____

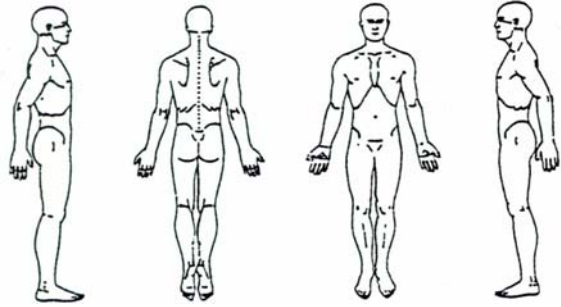


Draw/Shade the affected areas on the image(s) above to indicate your pain locations. Please use arrows to show the direction that the pain flows to or from these areas.

Please RATE YOUR PAIN! Please circle the accurate pain level below (1- low; 10-high) 1 2 3 4 5 6 7 8 9 10

#4 PAIN COMPLAINT: []

- 1. When did your symptoms appear? Date of onset: _____ Was it: Sudden Gradual
2. Is this condition getting progressively worse? Yes No Unknown
3. Describe your pain/complaint:
 Dull Sharp Ache Stabbing
 Deep Superficial Spasm/tension Numbness
 Tingling Burning Stiffness Pulling
4. Radiation: Does the pain go to other parts of the body?
 Yes No Where? _____
5. Degree: What is the degree of your pain?
 Mild Moderate Severe
6. Frequency: How often do you have this pain?
 Occasional Intermittent Frequent Constant
7. Duration: How long does the pain last? ___Min. ___Hrs. ___Days
8. What makes the pain worse?
 Standing Sitting Bending Twisting
 Walking Lifting Sleeping Heat
 Cold Stooping Sex Other
9. What makes the pain better?
 Sitting Standing Rest Heat Cold
 Aspirin/medication Other _____
10. Does it interfere with your :
 Work Sleep Daily routine Recreation
11. What treatment have you already received for this condition?
 Medications Surgery Physical therapy Chiropractic services None Other _____



Draw/Shade the affected areas on the image(s) above to indicate your pain locations. Please use arrows to show the direction that the pain flows to or from these areas.

Please RATE YOUR PAIN! Please circle the accurate pain level below (1- low; 10-high) 1 2 3 4 5 6 7 8 9 10

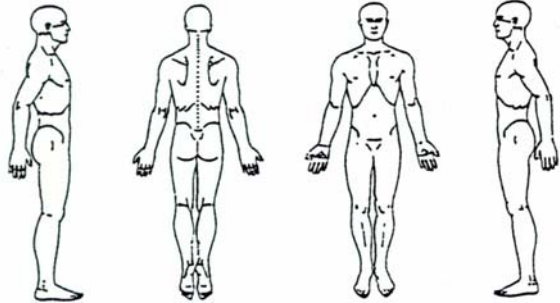


MUSCULO-SKELETAL (neck, back, leg, etc.) {fill out next four pages as needed}

#5

PAIN COMPLAINT: _____

- When did your symptoms appear?
Date of onset: _____ Was it: Sudden Gradual
- Is this condition getting progressively worse? Yes No Unknown
- Describe your pain/complaint:
 Dull Sharp Ache Stabbing
 Deep Superficial Spasm/tension Numbness
 Tingling Burning Stiffness Pulling
- Radiation: Does the pain go to other parts of the body?
 Yes No Where? _____
- Degree: What is the degree of your pain?
 Mild Moderate Severe
- Frequency: How often do you have this pain?
 Occasional Intermittent Frequent Constant
- Duration: How long does the pain last? ___Min. ___Hrs. ___Days
- What makes the pain worse?
 Standing Sitting Bending Twisting
 Walking Lifting Sleeping Heat
 Cold Stooping Sex Other _____
- What makes the pain better?
 Sitting Standing Rest Heat Cold
 Aspirin/medication Other _____
- Does it interfere with your :
 Work Sleep Daily routine Recreation
- What treatment have you already received for this condition?
 Medications Surgery Physical therapy Chiropractic services None Other _____



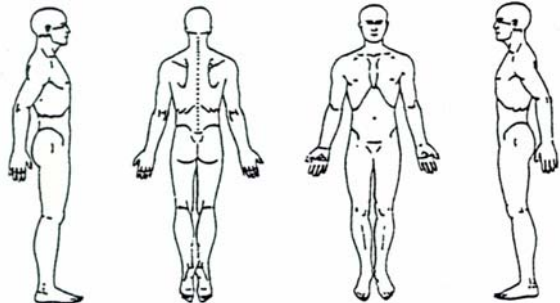
Draw/Shade the affected areas on the image(s) above to indicate your pain locations. Please use arrows to show the direction that the pain flows to or from these areas.

Please RATE YOUR PAIN!
Please circle the accurate pain level below (1- low; 10-high)
1 2 3 4 5 6 7 8 9 10

#6

PAIN COMPLAINT: _____

- When did your symptoms appear?
Date of onset: _____ Was it: Sudden Gradual
- Is this condition getting progressively worse? Yes No Unknown
- Describe your pain/complaint:
 Dull Sharp Ache Stabbing
 Deep Superficial Spasm/tension Numbness
 Tingling Burning Stiffness Pulling
- Radiation: Does the pain go to other parts of the body?
 Yes No Where? _____
- Degree: What is the degree of your pain?
 Mild Moderate Severe
- Frequency: How often do you have this pain?
 Occasional Intermittent Frequent Constant
- Duration: How long does the pain last? ___Min. ___Hrs. ___Days
- What makes the pain worse?
 Standing Sitting Bending Twisting
 Walking Lifting Sleeping Heat
 Cold Stooping Sex Other _____
- What makes the pain better?
 Sitting Standing Rest Heat Cold
 Aspirin/medication Other _____
- Does it interfere with your :
 Work Sleep Daily routine Recreation
- What treatment have you already received for this condition?
 Medications Surgery Physical therapy Chiropractic services None Other _____



Draw/Shade the affected areas on the image(s) above to indicate your pain locations. Please use arrows to show the direction that the pain flows to or from these areas.

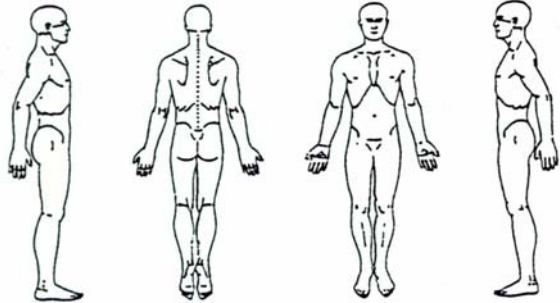
Please RATE YOUR PAIN!
Please circle the accurate pain level below (1- low; 10-high)
1 2 3 4 5 6 7 8 9 10



MUSCULO-SKELETAL (neck, back, leg, etc.) {fill out next four pages as needed}

#7 PAIN COMPLAINT: []

- 1. When did your symptoms appear? Date of onset: _____ Was it: Sudden Gradual
2. Is this condition getting progressively worse? Yes No Unknown
3. Describe your pain/complaint: Dull Sharp Ache Stabbing
4. Radiation: Does the pain go to other parts of the body? Yes No Where? _____
5. Degree: What is the degree of your pain? Mild Moderate Severe
6. Frequency: How often do you have this pain? Occasional Intermittent Frequent Constant
7. Duration: How long does the pain last? ___Min. ___Hrs. ___Days
8. What makes the pain worse? Standing Sitting Bending Twisting
9. What makes the pain better? Sitting Standing Rest Heat Cold
10. Does it interfere with your : Work Sleep Daily routine Recreation
11. What treatment have you already received for this condition? Medications Surgery Physical therapy Chiropractic services None Other _____

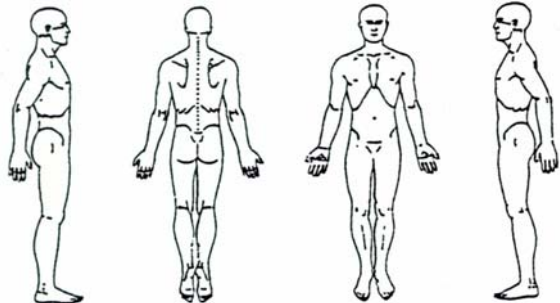


Draw/Shade the affected areas on the image(s) above to indicate your pain locations. Please use arrows to show the direction that the pain flows to or from these areas.

Please RATE YOUR PAIN! Please circle the accurate pain level below (1-low; 10-high) 1 2 3 4 5 6 7 8 9 10

#8 PAIN COMPLAINT: []

- 1. When did your symptoms appear? Date of onset: _____ Was it: Sudden Gradual
2. Is this condition getting progressively worse? Yes No Unknown
3. Describe your pain/complaint: Dull Sharp Ache Stabbing
4. Radiation: Does the pain go to other parts of the body? Yes No Where? _____
5. Degree: What is the degree of your pain? Mild Moderate Severe
6. Frequency: How often do you have this pain? Occasional Intermittent Frequent Constant
7. Duration: How long does the pain last? ___Min. ___Hrs. ___Days
8. What makes the pain worse? Standing Sitting Bending Twisting
9. What makes the pain better? Sitting Standing Rest Heat Cold
10. Does it interfere with your : Work Sleep Daily routine Recreation
11. What treatment have you already received for this condition? Medications Surgery Physical therapy Chiropractic services None Other _____



Draw/Shade the affected areas on the image(s) above to indicate your pain locations. Please use arrows to show the direction that the pain flows to or from these areas.

Please RATE YOUR PAIN! Please circle the accurate pain level below (1-low; 10-high) 1 2 3 4 5 6 7 8 9 10

HEALTH HISTORY – Please check the box(es) on the **LEFT SIDE** of the table that pertains to **YOU**; check the box(es) on the **RIGHT SIDE** of the page that pertains to your **FAMILY MEMBERS** (mother, father, sister, brother, cousin, aunt uncle, grandmother, etc.). If you have additional treatments, please write them on the back with the corresponding number (ex., put on back **8. Asthma – Proventil and Respiptone**).



YOUR HEALTH HISTORY					FAMILY HEALTH HISTORY		
	Ailments	Surgery Date	Age	Treatment	Relation	Deceased (Yes/No)	Age of Death
1	<input type="checkbox"/> AIDS/HIV					Yes / No	
2	<input type="checkbox"/> Alcoholism					Yes / No	
3	<input type="checkbox"/> Allergy Shots					Yes / No	
4	<input type="checkbox"/> Anemia					Yes / No	
5	<input type="checkbox"/> Anorexia					Yes / No	
6	<input type="checkbox"/> Appendicitis					Yes / No	
7	<input type="checkbox"/> Arthritis					Yes / No	
8	<input type="checkbox"/> Asthma					Yes / No	
9	<input type="checkbox"/> Bleeding Disorders					Yes / No	
10	<input type="checkbox"/> Breast Lump					Yes / No	
11	<input type="checkbox"/> Bronchitis					Yes / No	
12	<input type="checkbox"/> Bulimia					Yes / No	
13	<input type="checkbox"/> Cancer					Yes / No	
14	<input type="checkbox"/> Cataracts					Yes / No	
15	<input type="checkbox"/> Chemical Dependency					Yes / No	
16	<input type="checkbox"/> Chicken Pox					Yes / No	
17	<input type="checkbox"/> Cyst					Yes / No	
18	<input type="checkbox"/> Depression					Yes / No	
19	<input type="checkbox"/> Diabetes					Yes / No	
20	<input type="checkbox"/> Eczema					Yes / No	
21	<input type="checkbox"/> Emphysema					Yes / No	
22	<input type="checkbox"/> Epilepsy					Yes / No	
23	<input type="checkbox"/> Gallstones					Yes / No	
24	<input type="checkbox"/> Genital Warts					Yes / No	
25	<input type="checkbox"/> German Measles/Rubella					Yes / No	
26	<input type="checkbox"/> Glaucoma					Yes / No	
27	<input type="checkbox"/> Goiter					Yes / No	
28	<input type="checkbox"/> Gonorrhea					Yes / No	
29	<input type="checkbox"/> Gout					Yes / No	
30	<input type="checkbox"/> Heart Disease					Yes / No	
31	<input type="checkbox"/> Hemorrhoid					Yes / No	
32	<input type="checkbox"/> Hepatitis A					Yes / No	
33	<input type="checkbox"/> Hepatitis B					Yes / No	
34	<input type="checkbox"/> Hepatitis C					Yes / No	
35	<input type="checkbox"/> Hernia					Yes / No	
36	<input type="checkbox"/> Herniated Disc					Yes / No	
37	<input type="checkbox"/> Herpes					Yes / No	
38	<input type="checkbox"/> High Blood Pressure					Yes / No	
39	<input type="checkbox"/> High Cholesterol					Yes / No	
40	<input type="checkbox"/> Hysterectomy					Yes / No	
41	<input type="checkbox"/> Kidney Disease					Yes / No	



PAST HEALTH HISTORY

Please Check and Describe:

Major Surgery/Operations: Appendectomy Tonsillectomy Gall Bladder Hernia Back Surgery

Broken Bones Other _____

Major Accident or Falls: _____

Hospitalization (Other Than Above): _____

Previous Chiropractic Care: None Doctor's Name & Approximate Date of Last Visit _____

A. Have you ever had chiropractic care for other problems? Yes No If yes, when? _____

Do you take: Muscle Relaxers Pain killers Over-the-counter medications

B. Do you have a permanent disability rating? Yes No If yes, location: _____

Date received the rating: _____ Rating percentage: _____

C. List fractures, dislocations, concussions, falls (head injuries, car accidents, fender benders, gym injuries, horses, etc.)

<u>Date</u>	<u>Description</u>	<u>Treatment</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MISCELLANEOUS



EXERCISE	WORK ACTIVITY	HABITS	
<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Smoking	Packs/Day _____
<input type="checkbox"/> Moderate	<input type="checkbox"/> Standing	<input type="checkbox"/> Alcohol	Drinks/Week _____
<input type="checkbox"/> Daily	<input type="checkbox"/> Light Labor	<input type="checkbox"/> Drug (Recreational)	Times/Week _____
<input type="checkbox"/> Heavy	<input type="checkbox"/> Heavy Labor	<input type="checkbox"/> Coffee/Caffeine Drinks	Cups/Day _____
	<input type="checkbox"/> Computer Work	<input type="checkbox"/> High Stress Level	Reason _____



CHIROPRACTIC HEALTH QUESTIONNAIRE

Other prescription drugs: _____

Sleep _____ hrs/night Do you sleep on your: Back Side Stomach
Age of mattress _____ or waterbed _____ Is your bed comfortable? No Yes

What kind of pillow do you use? Thick Medium Thin None Support Age of pillow: _____

Do you wear: Heel lifts Shoe lifts Arch supports Orthotics, describe _____

CARE

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

Relief Care

Corrective Care

Check here if you want the Doctor to select the type of care appropriate for your condition

Date

Patient's Signature

If this is an accident related injury, please fill out the Accident Form. Thank You!



Relief Care

Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.



Corrective Care

Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

CHCC AGREEMENT

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

I agree to notify this doctor immediately whenever I have changes in my health condition(s) in the future.

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable.

I understand that in the case of default on my part, that necessitates Comprehensive Health and Chiropractic Centre or its agents to employ legal and/or collections counsel, I am responsible for collection charges incurred. These charges will be added to my bill.

Should I be unable to meet the terms of this agreement at any time, I agree to notify the office immediately.

Patient Signature

_____/_____/_____
Date

Parent or Guardian Signature (if patient is minor)

_____/_____/_____
Date

Staff Signature

_____/_____/_____
Date