**Pain Management**



2301 House Ave., Suite 201 • Cheyenne, WY 82001 • (307) 638-7757 • cheyenneregional.org

Date:

**Name:**

**Date of Birth:**

**Appointment Scheduled:**

To assist us in providing the best care possible, we ask for your assistance in the following areas:

1. Please ask your referring provider to send any records, labs, radiology reports, etc. that may pertain to their referral.
2. Please show up 15 minutes early for your appointment so our front office staff will be able to check you in in a timely manner. **Patients that are more than 10 minutes late may be rescheduled to a later time or date.**
3. Please bring a list of your current medications, prescribed and over the counter.

Please bring your **Insurance Card**, **Copayment** and a **Photo ID.**

If you do not have Medical Insurance or CRMC Charity Care your **NEW PATIENT VISIT DEPOSIT IS $180.00** and your **FOLLOW UP VISIT DEPOSIT IS $120.00.** This is required at the time of service and is not the total cost of your appointment.

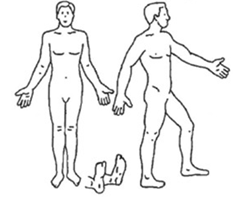
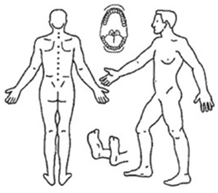
We look forward to seeing you soon. If you have any questions or need to reschedule your appointment, **please call the office at 307-638-7757.**

Thank you,

The Medical Specialty Clinic Staff

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pain Management Initial Evaluation**What is your main or worst pain problem: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Please list any other (secondary) areas of pain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pain History: Mark or Shade in the Areas You Have Pain (Put an X over the WORST area of pain)

The Following Questions Refer to Your Worst Area of Pain:  
How Did Your Pain Start: Gradual / Sudden Is the Pain Related to an Injury: NO YES  
Explain When Your Pain Started:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Has the Pain Increased or Changed Recently: NO YES If Yes, Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
On a Scale from 0 (No Pain) to 10 (Worst Pain Imaginable) Please Rate Your Pain When:  
Your Pain is at its Worst: \_\_\_\_\_\_\_\_\_\_\_\_ Your Pain at its Best: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Your Pain on Average: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Your Goal for Pain Level: \_\_\_\_\_\_\_\_\_\_\_\_  
  
How Often Do You Have Your Pain: All of the Time / Continuously, but Gets Better & Worse / Sometimes  
  
How Would You Describe Your Pain: (Check All That Apply)

* Aching
* Burning
* Cramping
* Dull
* Pressure
* Sharp
* Shooting
* Squeezing
* Throbbing
* Tight
* Numbness
* Tingling
* Changing
* Other: \_\_\_\_\_\_\_\_\_\_\_\_

Which of these Activities Make Your Pain Better: (Check All That Apply)

* Distraction
* Heat
* Ice
* Massage
* Meditation
* Movement
* Relaxation
* Rest
* Sleep
* Medications
* Nothing
* Other: \_\_\_\_\_\_\_\_\_\_\_\_

Which of these Activities Make Your Pain Worse: (Check All That Apply)

* Nothing
* Rest
* Changing Position
* Standing
* Sitting
* Walking
* Bending
* Twisting
* Stairs
* Activity / Movement
* Stress
* Weather
* Straining
* Intercourse
* Other: \_\_\_\_\_\_\_\_\_\_\_\_

What Are You Currently Using to Treat Your Pain (Medications, Heat/Ice, Activity, Therapies, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pain History: Check the Box that Best Describes Your Past Treatment and its Effects on Your Pain**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Treatment** | **Effect of Treatment** | | | |
| **Helped** | **Didn’t Help** | **Made Pain Worse** | **Not Tried** |
| Physical Therapy |  |  |  |  |
| Chiropractic |  |  |  |  |
| Massage |  |  |  |  |
| Water / Pool Therapy |  |  |  |  |
| Acupuncture / Acupressure |  |  |  |  |
| TENS Unit |  |  |  |  |
| Injections (Please Specify: Spine, Muscle, Joint, Nerve, other) |  |  |  |  |
| Other Professional Treatment |  |  |  |  |
| Surgery (Type & Date) |  |  |  |  |
| Behavioral Therapy |  |  |  |  |
| Other |  |  |  |  |

**Sleep** (Check All That Apply)Overall Quality: Good / Fair / Poor Total Hours per Night: \_\_\_\_\_\_\_\_\_\_\_\_ Total Hours At a Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Difficulty Falling Asleep: Never / Sometimes / Always  
Frequent Nighttime Awakenings: Never / Sometimes / Always  
Difficulty Falling Asleep if Awakened: Never / Sometimes / Always  
Sleep Medications You are Using: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Past Sleep Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mood** (Check All That Apply)  
Please Describe Your General Mood Over the Last Week: (Check All That Apply)

* Normal
* Generally Happy
* Sad
* Depressed
* Helpless
* Lack of Enjoyment
* Irritable
* Anxious
* Fearful
* Guilty
* Worried
* Angry
* Hopeless
* Up and Down
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do You Have a History of Mood Problems (Anxiety, Depression, Other): NO YES If Yes, Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Are You Currently Being Treated for Mood Problems: NO YES If Yes, By Who: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Mood Medications that You are Currently Taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Past Mood Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Function**  
Currently, I am Able to:  
Care for My Basic Needs (Bathe, Dress, Eat): Always / Most of the Time / Sometimes / Never  
Care for Myself at Home (Cook, Clean, Laundry) : Always / Most of the Time / Sometimes / Never  
Drive Short Distances and Run Errands: Always / Most of the Time / Sometimes / Never  
Do Light Activity (Yard Work, Walk 15 minutes) : Always / Most of the Time / Sometimes / Never  
Do Moderate Activity (Active for 30 minutes or More) : Always / Most of the Time / Sometimes / Never  
  
On a Scale from 0 (Bed-Bound) to 100 (Doing Everything You Want to Do) Please Rate Your Overall Function: \_\_\_\_\_\_\_\_  
Please List Any Activity Restrictions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Do You Do Any Regular Physical Activity: NO YES If Yes, Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My Goal is to be Able to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pain Medications**

|  |  |  |
| --- | --- | --- |
| **Current Pain Medication** | **Dosage** | **Frequency** |
|  |  |  |
|  |  |  |
|  |  |  |

|  |  |  |
| --- | --- | --- |
| **Previous Pain Medication** | **Did It Help** | **Why was it Stopped** |
|  | Yes / Some / No | Didn’t Help / Side Effects (List): |
|  | Yes / Some / No | Didn’t Help / Side Effects (List): |
|  | Yes / Some / No | Didn’t Help / Side Effects (List): |
|  | Yes / Some / No | Didn’t Help / Side Effects (List): |
|  | Yes / Some / No | Didn’t Help / Side Effects (List): |

Medication Goal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
**Past & Current Medical History** (Check All That Apply)

* Alcohol Abuse
* Anesthesia Problems
* Anxiety
* Arthritis
* Asthma
* Bleeding Disorder
* Bowel Problems
* Cancer
* Chest Pain
* Colostomy
* Congestive Heart Failure
* COPD
* Depression
* Diabetes
* Dizziness
* Emphysema
* Fainting
* Heart Attack
* Heart Valve Problems
* Hepatitis
* Hiatal Hernia
* High Blood Pressure
* HIV
* Irregular Heartbeat
* Kidney Problems
* Liver Problems
* Malignant Hyperthermia
* TIA (Mini-stroke)
* Reflux Disease
* Obesity
* Seizure
* Stroke Illness
* Thyroid
* Transfusion
* Ulcer
* Urinary Problems
* Urostomy
* Pancreatitis
* Migraine / Headache
* Other: \_\_\_\_\_\_\_\_\_\_\_\_

**Past Surgical History** (Check All That Apply)

* Appendectomy
* Coronary Bypass
* Gall Bladder Removed
* Hernia Repair
* Hysterectomy
* Tonsils & Adenoids
* Joint Surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_
* Joint Replacement: \_\_\_\_\_\_\_\_\_
* Spine Surgery: \_\_\_\_\_\_\_\_\_\_\_\_
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History** (List Any Major Illnesses That Run in Your Family)

|  |  |  |
| --- | --- | --- |
| **Family Member** | **Living / Deceased** | **Major Illnesses** |
| Father: |  |  |
| Mother: |  |  |
| Siblings: # Sisters \_\_\_\_\_\_ Brothers\_\_\_\_ |  |  |
| Children: # Daughters \_\_\_\_ Sons\_\_\_\_\_\_ |  |  |

**Diagnostic Tests** Which of the Following Tests for This Pain Have Been Done (List Most Recent Tests)

|  |  |  |  |
| --- | --- | --- | --- |
| **Diagnostic Test** | **Body Part** | **Approximate Date** | **Where Was it Done** |
| X-Ray |  |  |  |
| CT Scan |  |  |  |
| MRI Scan |  |  |  |
| EMG/Nerve Study |  |  |  |
| Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |

**Social / Occupational History**  
Do You Smoke or Use Tobacco: NO / FORMER / YES If Yes, How Much: \_\_\_\_\_\_\_\_ For How Long: \_\_\_\_\_\_  
Do You Drink Alcohol: NO / FORMER / YES If Yes, How Much: \_\_\_\_\_\_\_\_ For How Long: \_\_\_\_\_\_  
Do You Use Illegal Drugs: NO / FORMER / YES If Yes, How Much: \_\_\_\_\_\_\_\_ For How Long: \_\_\_\_\_\_

Marital Status: Married / Single / Separated / Divorced / Widowed  
Children: None / # Daughters \_\_\_\_\_ / # Sons \_\_\_\_\_   
Living Situation: Alone / Spouse / Children / Parents / Roommate / Other / # People Living in Home: \_\_\_\_\_\_\_\_  
  
Employment: Full-Time / Part-Time / Unemployed / Retired / Disability Since: \_\_\_\_\_\_\_\_\_  
Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For This Pain, Are You Involved in: Litigation / Worker’s Compensation  
If You are Not Working, Do You Plan to: Return to Your Old Job / Take a Different Job / Not Return To Work

Please List Any Concerns or Things We Should Know About Your Pain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Review of Symptoms** (In the Last Month Have You Had: Check All That Apply)

|  |  |  |  |
| --- | --- | --- | --- |
| **Constitution** | **Eyes** | **Gastroenterology** | **Endocrinology** |
| * Fever | * Blurred Vision | * Heartburn | * Easy Bruising / Bleeding |
| * Chills | * Light Sensitivity | * Nausea | * Environmental Allergies |
| * Weight Loss | * Eye Pain | * Vomiting | * Excessive Thirst |
| * Fatigue | * Eye Discharge | * Abdominal Pain |  |
| * Excessive Sweating | * Eye Redness | * Diarrhea | **Neurological** |
| * Weakness |  | * Constipation | * Dizziness |
|  | **Cardiovascular** | * Blood in Stool | * Headaches |
| **Skin** | * Chest Pain | * Dark Stool | * Tingling |
| * Rash | * Palpitations |  | * Tremor |
| * Itching | * Shortness of Breath When   Laying Down | **Genitourinary**   * Painful / Difficult Urination | * Sensory Change * Speech Change |
| **Head/Ear/Nose/Throat**   * Hearing Loss | * Pain or Cramping   in Legs With Elevation | * Urgency * Frequency | * Weakness in One   Extremity or Muscle Group |
| * Ringing in Ears * Ear Pain | * Shortness of Breath &   Coughing at Night | * Blood in Urine * Flank Pain | * Seizures * Loss of Consciousness |
| * Ear Discharge |  |  |  |
| * Nosebleeds | **Respiratory** | **Musculoskeletal** | **Psychiatric** |
| * Congestion | * Cough | * Muscle pain | * Depression |
| * Sinus Pain | * Coughing Up Blood | * Neck Pain | * Suicidal Ideas |
| * Vibrating Nose   When Breathing | * Coughing Up Mucus * Shortness of Breath | * Back Pain * Joint Pain | * Substance Abuse * Hallucinations |
| * Sore Throat | * Wheezing | * Falls | * Nervous / Anxious |
|  |  |  | * Insomnia |
|  |  |  | * Memory Loss |



**STAMPER OR PATIENT LABEL**

**Authorization to Disclose Health Information to Family or Other**

Patient’s Name: Date of Birth:

Street Address:

City: State: Zip:

I hereby authorize Cheyenne Regional Medical Center to disclose health information to the following contact(s):

**Contact #1**

Name: Relationship to me:

Home Phone: Alternate Phone:

**Contact #2**

Name: Relationship to me:

Home Phone: Alternate Phone: \_\_\_\_\_\_

The information that may be disclosed or discussed is related to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

(e.g. current treatment, related to incident)

for the purpose of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, and may include the following:

🞏 Treatment and Progress Notes 🞏 Nursing Records

🞏 Treatment Plans 🞏 Lab(s)

🞏 Financial Records 🞏 Medications

🞏 Other (Please Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Once your health information has been disclosed, re-disclosure of your health information by the recipient may no longer be protected by law. You may revoke this authorization in writing at any time. Please note that cancellation by telephone must be confirmed in writing. Your revocation will not affect any disclosure made under this authorization prior to your revocation.

I understand that authorizing the disclosure of this health information is voluntary and I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

By signing this form I understand that Cheyenne Regional Medical Center may discuss past, present, or future health care issues with the above named contacts from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ through\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Start End (not more than 1 year from the date of this authorization)

Signature: Date:

If Personal Representative Signed:

Personal Representative Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Page 1 of 1

ROI

\*ROI\*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name: (Last, First MI)  *Preferred Name:* | | Sex (M/F) | Birth Date: | |
| Mailing Address: | | | Social Security #: | |
| City, State, Zip: | | | Primary Care Provider: | |
| Phone Numbers: *Check Which Number is Preferred*  HOME # MOBILE # WORK #  \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Referring Provider: | |
| Email: | |
| *Emergency Contact Name:* | *Contact Relationship:* | | *Emergency Contact Phone:* | |
| **Check next to the box that applies:**  *These questions are used for hospital survey purposes*  **Marital Status: Ethnicity: Race:**  Married Hispanic/Latino American Indian or Alaskan Native  Single Not Hispanic or Latino Asian  Divorced Unknown Black or African American  Widowed More than One Race  Separated Native Hawaiian  Partner Pacific Islander  Other White/Caucasian  Other | | | | **Primary Language:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Preference of Religion:**  **U.S State of Birth:**  If *OTHER* please check box |
| ***How did you hear about us?*** |
| **Employer:** | | | | Full Time Student N/A  Part Time Retired |

|  |  |  |  |
| --- | --- | --- | --- |
| **Guarantor/Responsible Party**: If ***SELF*** (Same as above info Check Box) *If different, please fill out below:* | | | |
| Relationship to Patient: | Best Phone Number: | | |
| Name: (Last, First, Middle) | | Sex (M/F) | Birth Date: |
| Mailing Address: | | City, State, Zip: | |

|  |  |  |  |
| --- | --- | --- | --- |
| **INSURANCE:** *If you are going through Workers Compensation skip to the last section* | | | |
| **PRIMARY INSURANCE COVERAGE:** | | **SECONDARY INSURANCE COVERAGE:** | |
| *Policy Holder Name:* | *Relationship to Patient:* | *Policy Holder Name:* | *Relationship to Patient:* |
| *Policy #* | *Group #* | *Policy #* | *Group #* |
| *Insurance Start Date:* | | *Insurance Start Date:* | |
| ***WORKERS COMPENSATION CLAIM # Date of Injury:*** | | | |



2301 House Ave., Suite 201 • Cheyenne, WY 82001 • (307) 638-7757 • cheyenneregional.org

**CANCELLATION AND MISSED APPOINTMENT/NO SHOW PROCEDURE**

Dear Valued Patient,

Our goal is to provide timely quality medical care. No-Shows and late cancellations inconvenience those who need access to medical care in a timely manner. This policy enables us to better utilize available appointments for all of our patients.

**CANCELLATION OF AN APPOINTMENT**

In order to be respectful of the medical needs of other patients, please be courteous and call the Medical Specialty Clinic promptly if you are unable to show up for an appointment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. 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 an appointment, please call (307) 638-7757. If you do not reach the receptionist you may leave a detailed message on our voicemail. Please leave your name and phone number and we will return your call to give you the next available appointment time.

**LATE CANCELLATION**

A late cancellation is someone who does not cancel their appointment before 24 hours of their scheduled appointment time.

**NO-SHOW PROCEDURE**

A “no-show” is someone who fails to arrive for a scheduled appointment without cancelling the appointment prior to the scheduled time.

* First no show: There will be no charge
* Second no show: May result in a $25 fee billed to your account
* Third no show: May result in an additional $25 fee billed to your account and dismissal from our practice.

***I have read and understand the Medical Specialty Clinic Cancellation and Missed Appointment/No Show Procedure.***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Printed Name Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Today’s Date

***The Medical Specialty Clinic values you as a patient and strives to provide you with excellent medical services! Thank you for your support of this process****.*