**Pulmonology**



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.
4. **Pulmonary Patients: If the New Patient Paperwork is NOT completed at the time of visit your appointment will be CANCELLED and RESCHEDULED.**

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

**Medical Specialty Clinic: Pulmonology**

**Patient History Questionnaire**

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
**Doctor who sent you:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**List of all the doctors you see:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Reason for your visit:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**History of Present Illness  
Location:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Duration:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Where on the body symptoms occur) (How long have you had symptoms/pain? How long does it last?)

**Severity:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Quality:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
(Severe, worse, slightly, symptom/pain scale 1- 10) (Character of symptom/pain, burning, gnawing, stabbing)

**Timing:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Context:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
(When symptoms occur? After meals or exercise, etc.?) (Situation associated with symptom?)

**Modifying Factors:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Associated Signs/Symptoms:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
(Things that make symptoms better or worse) (Other things that happen when this symptom occurs)

**Past History Please circle YES or NO if you have any of the following medical problems:**

High Blood Pressure: YES NO Diabetes: YES NO Heart Trouble: YES NO  
Respiratory Problems: YES NO Stroke: YES NO Cancer: YES NO  
Sleep Problems: YES NO Bleeding Problems: YES NO HIV/AIDS: YES NO  
Other Problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATION ALLERGIES:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **Current Medication** | **Dosage** | **Frequency** |
|  |  |  |
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**Past Hospitalizations / Surgeries / Injuries and Approximate Dates:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Family History: Please List any Medical Problems with Your Relatives**

Father: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mother: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Siblings: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
**Social History:  
Do You Use Tobacco?**Never   
Yes (Cigarette Packs Per Day: \_\_\_\_\_ Cigars per Day: \_\_\_\_ Daily Chewing Tobacco: \_\_\_)   
Former (Quit Date: \_\_\_\_\_\_ Cigarette Packs per Day: \_\_\_\_\_ Cigars per Day: \_\_\_\_ Daily Chewing Tobacco: \_\_\_)  
Exposed to Secondhand Smoke: YES NO

Alcohol Use: Never Rarely Moderate Daily How much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Drug Use: Never Type and Frequency? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
**ADVANCED DIRECTIVES: Please Circle YES or NO**Do you have a living will: YES NO  
Do you have advanced directives: YES NO  
Do you have designated Durable Power of Attorney for health care: YES NO  
If yes, name of durable power of attorney\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
**Review of Symptoms: Please Circle YES or NO if you have any of following problems:**

**Constitutional Ear/Nose/Mouth/Throat**Good General Health: YES NO Hearing Loss or Ringing: YES NO  
Recent Weight Changes: YES NO Sinus Problems: YES NO  
Night Sweats / Fever: YES NO Chronic Sinusitis: YES NO  
Fatigue: YES NO Frequent Infection: YES NO Nose Bleeds: YES NO   
**Eyes** Sore Throat / Voice Change: YES NO  
Wear Glasses: YES NOBlurred/Double Vision: YES NO **Cardiovascular**   
Eye disease or injuries: YES NO Chest Pain: YES NO Glaucoma: YES NO Palpitations: YES NO Heart Trouble: YES NO  
**Respiratory** Swelling hands/feet: YES NO  
Shortness of breath: YES NOCough: YES NO **Gastrointestinal**   
Wheezing/Asthma: YES NO Nausea/Vomiting: YES NO   
Do You Know Your Baseline Peak Flow? \_\_\_\_\_\_\_\_\_ Abdominal pain: YES NO  
Coughing up blood: YES NO Rectal bleeding: YES NO  
History of Respiratory Infection: YES NO Bowel problems: YES NO   
Use Oxygen: YES NO Heartburn: YES NO   
If yes: How Many Liters? \_\_\_\_Date Started: \_\_\_\_\_\_\_

**Musculoskeletal**  **Neurological**    
Muscle pain/cramps: YES NO Frequent Headaches: YES NO  
Stiffness/swelling joints: YES NOParalysis or tremors: YES NO   
Joint pain: YES NO Seizures: YES NO  
Trouble Walking: YES NO Numbness/tingling: YES NO

**Skin/Breast Endocrine**Change in hair or nails: YES NO Excessive thirst/urination: YES NO  
Rashes or itching: YES NO Thyroid disease: YES NO  
Breast lump: YES NO Hormone problems: YES NO  
Breast pain or discharge: YES NO

**Hematologic/Lymphatic Allergic/Immunologic**Bruise Easily: YES NO Food allergies: YES NO  
Slow to heal: YES NO Aspirin Allergies: YES NO  
Enlarged glands: YES NO Antibiotic Allergies: YES NO  
 Seasonal Allergies: YES NO

**Genitourinary Psychiatric**Blood in urine: YES NO Insomnia: YES NO  
Kidney Stones : YES NO Confusion/Memory loss: YES NO  
Sexual Problems: YES NO Depression: YES NO   
Testicle Pain: YES NO N/A Tired/Fatigued: YES NO   
Menstrual Problems: YES NO N/A  
 **Have You Experienced These Symptoms in the Past Month: Please Circle YES or NO**   
**Wheezing:** YES NO (If Yes, Answer the Following) **Shortness of breath:** YES NO (If Yes, Answer the Following)  
 After exposures: YES NO At rest: YES NO  
 With exercise: YES NO With minimal exertion: YES NO   
 At rest: YES NO With moderate exertion: YES NO Worse at night: YES NO Climbing Stairs: YES NO  
 Walking <1 Block: YES NO  
**Cough:** YES NO (If Yes, Answer the Following) **Other:**   
 Production of sputum: YES NO Chest tightness: YES NO  
 Dry Cough: YES NO Inability to take full breaths: YES NO  
 Coughing up Blood: YES NO Inability to lay flat at night: YES NO  
 Nighttime cough: YES NO New or worsening swelling: YES NO  
   
**EXPOSURES (TRIGGERS): Any of the Following Make Your Breathing Worse? Please Circle YES or NO** Cold Air: YES NO Wood Smoke: YES NO  
Wind: YES NO Tobacco Smoke: YES NO  
Respiratory infections : YES NO Allergies (hay fever): YES NO  
Emotions/Stress: YES NO Exercise: YES NO  
Perfumes: YES NO Cleaning fluids/strong fumes: YES NO

**OCCUPATIONAL HISTORY: Have you had any of the following exposures? Please Circle YES or NO**

Asbestos: YES NO Coal Mining: YES NO  
Chemicals/Fumes: YES NO Other Mining: YES NO  
Explanation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 **MILITARY HISTORY (if applicable):**What branch of the service? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Dates of service? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Duties\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exposures: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SLEEP HISTORY: Please Circle YES or NO**Do you have a history of sleep apnea: YES NO Any known sleep disorder: YES NO  
Do you snore: YES NO Stop breathing at night: YES NO  
Have excessive leg movement: YES NO Sleep Walk: YES NO  
Do you wear a CPAP/BIPAP: YES NO  
 **VACCINATION HISTORY: Please Circle YES or NO**Did you receive the usual childhood vaccinations: YES NO  
Do you receive the yearly influenza vaccination: YES NO  
Have you received a pneumonia vaccine: YES NO (If yes when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_)

**OTHER: Please answer the following questions**

Have you traveled outside the U.S. within the past six months: YES NO

History of Heartburn or Reflux Disease: YES NO

Are you currently on home oxygen: YES NO   
(If Yes, Answer the Following) Date oxygen therapy started: \_\_\_\_\_\_\_\_ Current setting(s): \_\_\_\_\_\_\_\_\_\_

What times of day do you wear oxygen? Circle one:   
All the time/Only at Night/Only when I feel short of breath/Only with exertion /Only when I am at rest

Do you have any pets at home: YES NO (If So What Kind \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)  
Are you living or working on a ranch or farm: YES NO

Current hobbies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**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:*** | | | |



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**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****.*