Patient Information

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you known by any other name/nickname? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Previous Name? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physical Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do you prefer to be contacted:  [  ] Home   [  ] Cell   [  ] Work   [  ] Caretaker/Spouse/Other

Social Security #:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-Mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: Employment Status:

 [ ] Male [ ] Full Time

 [ ] Female [ ] Part Time

 [ ] Retired

Marital Status: [ ] Self Employed

 [ ] Military

 [ ] Married [ ] Not employed/Student

 [ ] Single

 [ ] Divorced Preferred Method for Electronic

 [ ] Widowed Appointment Reminder:

 [ ] Separated

 [ ] Text

Race: [ ] Phone Call

 [ ] E-Mail

 [ ] Asian

 [ ] Black or African American

 [ ] Indian or Alaska Native

 [ ] Native Hawaiian or Other Pacific For the selected method above, what phone

 [ ] White number or e-mail do you prefer we send the electronic reminder to?

Ethnicity:

 [ ] Hispanic or Latino \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 [ ] Not Hispanic or Latino

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is the above method for someone other

 than the patient: [ ] Yes [ ] No

Current Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency and Additional Contact Information

1st Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Should we list the person above as the Primary Contact, *Instead of the Patient?* [ ] Yes [ ] No

Is this person granted full Health Information access: [ ] Yes [ ] No If not, what are the exclusions?

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

2nd Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Should we list the person above as the Primary Contact, *Instead of the Patient?* [ ] Yes [ ] No

Is this person granted full Health Information access: [ ] Yes [ ] No If not, what are the exclusions?

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

Miscellaneous

How did you hear about us: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Were you referred to us: [ ] Yes [ ] No

If yes, by whom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you currently have Home Health: [ ] Yes [ ] No Name of Home Health Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party Information

 If there is someone other than the patient who is responsible for statements / bills to be sent to or

 The Primary Card Holders Information should be listed below.

Responsible Party Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Medical History** (Check ALL that apply) **Social History** (Check ALL that apply)

Acute Kidney Injury [ ] Coronary Kidney Disease [ ] Smoker [ ] Yes [ ] No

Coronary Artery Disease [ ] Thyroid disease [ ] if YES, How Many Packs Per Day ­­**\_\_\_\_\_\_\_\_\_\_\_\_**

Atrial Fibrillation [ ] Congestive Heart Failure [ ] Quit [ ] Yes [ ] No When **\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Coronary Stents [ ] Kidney Stones [ ] Alcohol [ ] Yes [ ] No How often **\_\_\_\_\_\_\_\_\_\_\_**

Diabetes [ ] Diabetic Retinopathy [ ] Street Drugs [ ] Yes [ ] No Which Drug **\_\_\_\_\_\_**

Diabetic Neuropathy [ ] Chronic Back Pain [ ] Exercise [ ] Yes [ ] No

Pacemaker [ ] Defibrillator [ ] CVA [ ] / TIA [ ] Race / Ethnicity **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

High Cholesterol [ ] Hypertension [ ] Employment **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Asthma [ ] / COPD [ ] Heart Valve Dysfunction [ ]

Autoimmune Disease [ ] Lupus [ ] **Family History –** Relative (Mother, Father, etc.)

Vitamin Deficiencies [ ] Immune Deficiencies [ ] Kidney Disease [ ] Dialysis [ ]

Electrolyte Abnormalities [ ] Cardiovascular Disease [ ] Heart Disease [ ]

**Other:** Hypertension **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 Diabetes **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Cancer **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Autoimmune Diseases **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Other **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **DRUG ALLERGIES [ ] YES [ ] NO**

 **LIST: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Surgeries:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MEDICATIONS – LIST DOSE AND FREQUENCY**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Chief Complaints: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Weight Loss [ ] Gain [ ]Weakness [ ] **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Vision change [ ]Chest Pain [ ] **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Palpitations [ ]Nausea [ ] Vomiting [ ]  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Leg Swelling [ ]Rash [ ] Itching [ ] **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Change in Urine Color [ ]Flank Pain [ ] **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Pain with Urination [ ]Blood in Urine [ ] **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Shortness of Breath [ ]Abdominal Pain [ ] **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Nerve Pain [ ]Fatigue [ ] **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Depression [ ]Anxiety [ ] **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PHARMACY NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authority to Release Protected health Information**:

I hereby authorize {Name} \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to release information identified in this authorization from the medical records of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_{Patient’s Name} and provide such information to Nephrology & Wellness.

**Information to be Released** – Covering the Periods of Health Care From {Date} \_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_

**[ ] Complete Medical Record** **[ ] Partial Medical Record Specifically to include:**

[ ] History & Physical [ ] X-Ray, Ultrasound, CT Scans [ ] Other

[ ] Most Recent Office Visit [ ] Biopsy

[ ] Most Recent Labs [ ] Current Medication List

**Purpose of the Requested Disclosure of Protected Health Information**: I am authorizing the release of my Protected Health Information for the following purposes: At Patient’s Request

**Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release**: I understand if my medical or billing records contains information in references to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, hepatitis B or C testing, and/or other sensitive information, I agree to its release please check one: **[ ] Yes [ ] No**

I understand if my medical record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release – please check one: **[ ] Yes [ ] No**

**Expiration Date:** Unless revoked, this authorization will expire on the following date, or after the following time period or event: **10 years**

**Right to Revoke Authorization:** Except to the event that action has already been taken in reliance on this authorization, this authorization may be revoked at any time by submitting a written notice.

**Re-disclosure:** I understand the information disclosed by this authorization may be subjected to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

**Patient Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship if not Patient**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONSENT TO TREAT/ RELEASE OF INFORMATION / FINANCIAL RESPONSIBILITY GUARANTEE**

1. CONSENT TO MEDICAL CARE: by my signature below, I warrant that I am the patient or legal representative of the registered patient named on the Patient Registration Form. I hereby request and authorize the physician and other health care providers of Nephrology & Wellness and their professional staff, to evaluate and recommend any testing and/or additional treatment which in their professional judgement is deemed necessary to diagnose and/or treat the condition(s) that have been brought about my seeking medical care services for at the offices of the Practice. I understand that the practice of medicine is not an exact science, and that there are risks and benefits associated with receiving medical treatment rendered by the physicians and the professional staff of the Practice. I understand I have the right to refuse treatment or recommendations.
2. RELEASE OF MEDICAL RECORD INFORMATION: I hereby authorize Nephrology & Wellness to disclose all or any part or the contents of the medical record of the patients named on this Registration Form to such insurance companies, organizations, or agencies that may be concerned with the payment of medical services rendered to the registered patient consistent with Federal HIPPA Regulations. I hereby acknowledge Nephrology & Wellness has the right to use and disclose my health information to other health care providers or organizations that are assisting in my treatment and care or with a specialist to whom I have agreed the practice can refer me to. I understand I have the right to restrict how my health information is used or disclosed and that the practice is not required to agree to any restriction but if an agreement is reached, the practice is bound by the agreement.
3. ASSIGNMENT OF INSURANCE BENEFITS: I hereby request and authorize that any and all insurance benefits due and payable for medical services rendered to the patient, be paid directly to **KSW, LLC.**
4. FINANCIAL AGREEMENT AND GUARANTEE: I accept full and complete financial responsibility for all medical services rendered to the registered patient and agree to any and all insurance co-payments, deductibles and co-insurances that may be rendered under the terms of my medical insurance policies, as well as pay for any medical care that is considered a “non-covered” service under the terms of my medical insurance plan.
5. CO-PAYS; MUST BE PAID AT THE TIME OF EACH VISIT: This is the policy of your insurance company, which our office is REQUIRED to comply with.
6. NO SHOWS & 24-HOUR CANCELLATION FEES: Nephrology & Wellness reserves the right to charge a fee of $25.00 for any missed appointments (“NO SHOWS”) and appointments which, absent a compelling reason, are not cancelled with a 24-Hour notice. “NO SHOW” fee will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple “NO SHOWS” or CANCELLED appointments in any 12-month period may result in termination from our practice.
7. FORMULARY BENEFITS DATA: Formulary Benefits data are maintained by 3rd party administration of prescription drug programs whose primary responsibilities are process and pay drug claims and maintain formularies. I give permission to Nephrology & Wellness to access my pharmacy benefits. This will enable Nephrology & Wellness to determine pharmacy benefits and copays, check if a prescribed medication is covered under my insurance plan, display alternatives, access a historical list of all medications prescribed by any provider, determine if a patient’s health plan allows electronic prescribing to mail order pharmacies, and if so, e-prescribe to these pharmacies.

Patient Name (Print) Date of Birth

Signature of Patient/Legal Representative Date

**TEXT MESSAGING & EMAIL MESSAGING CONSENT FORM**

I consent to the practice of Nephrology & Wellness contacting me by text messaging or email for the purpose of health promotions and for appointment reminders.

I acknowledge that appointment reminders by text or email are an additional service, and that the responsibility of attending or cancelling appointments still rests with me. I can cancel the text or email reminders at any time.

I agree to advise the practice if my mobile number or email changes or if it is no longer in my possession.

**Preferred Method for Electronic Appointment Reminder:**

**Text \_\_\_\_\_**

**Phone \_\_\_\_\_**

**E-mail \_\_\_\_\_**

For the selected method above, what phone number or email address do you prefer we send the electronic reminder:

Number/E-mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (Please Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_