PATIENT REGISTRATION

PATIENT INFORMATION

Full Name_____ Preferred Name_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Birth Date_____ Age_____ Sex ___M ___F

SS#_____ Email Address_____

RESPONSIBLE PARTY INFORMATION

Will be contacted for appointment reminders

Full Name_____ Relationship to Patient_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Birth Date_____ Sex ___M _____F Email Address_____

SS#_____ Marital Status _____Married ___Single ___Divorced ___Separated ___Widowed

RESPONSIBLE PARTY INFORMATION

☐ ***Check if NO DENTAL INSURANCE (Secondary Insurance Information on back)***

Insured Full Name_____ Relationship to Patient_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Birth Date_____ Sex _____M _____F SS#_____

Policy #_____ Group #_____

Employer_____ Ins Name _____ Ins Phone_____

Claims Address_____ City_____ State_____ Zip_____

OTHER INFORMATION

Emergency Contact_____

Emergency Phone_____

Relationship to Patient_____

Preferred Pharmacy_____

Pharmacy Phone_____

How did you hear about our office?

REFERRED BY (check one):

☐Doctor/Dentist_____

☐ Friend_____

☐ Amigo Staff_____

☐ School/Daycare_____

☐ Phone Book

☐ Website

☐ Radio

☐ Newspaper

*****As a courtesy, a claim will be filed to your primary insurance. The *estimated* patient portion is due when services are rendered.*****

PATIENT REGISTRATION (CONTINUED)

PATIENT INFORMATION – 2nd Child

Full Name_____ Preferred Name_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Birth Date_____ Age_____ Sex ___M ___F

SS#_____ Email Address_____

PATIENT INFORMATION – 3rd Child

Full Name_____ Preferred Name_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Birth Date_____ Age_____ Sex ___M ___F

SS#_____ Email Address_____

PATIENT INFORMATION – 4th Child

Full Name_____ Preferred Name_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Birth Date_____ Age_____ Sex ___M ___F

SS#_____ Email Address_____

SECONDARY INSURANCE INFORMATION
(if applicable)

Insured Full Name_____ Relationship to Patient_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Birth Date_____ Sex ____M ____F SS#_____

Policy #_____ Group #_____

Employer_____ Ins Name _____ Ins Phone_____

Claims Address_____ City_____ State_____ Zip_____

AMIGO CHILDREN'S DENTAL, P.A.
Howard H. Hunt Jr., DDS
www.amigochildrensdental.com

DENTAL INFORMATION

Patient Name_____ **Date** _____

For the following questions, please check the appropriate answer and fill out the necessary information. Your answers are for our records only as they help us provide you with a more thorough visit and will be considered strictly confidential.

DENTAL INFORMATION

What is the reason for your child's first visit to our dental office? ___Consultation ___Emergency ___Preventative/Exam ___Other

Parent level of apprehension? ___High ___Medium ___Low ___None

Name of previous dentist_____ Telephone_____ May we contact previous dentist for records and X-rays? ___Y ___N

Has your child ever had an injury to the teeth, lips, tongue or chin in the past? ___Y ___N

DIETARY FACTS

Does your child eat between meals? ___Y ___N

Is your child a good eater? ___Y ___N

Does s/he eat a balanced diet? ___Y ___N

At what age was bottle/nursing stopped? ____yrs____mo

Please list your child's favorite snacks:

FLOURIDE & TOOTH BRUSHING

Is your child taking fluoride supplements presently? ___Y ___N If Yes, what form? _____

Has your child received fluoride supplements in the past? ___Y ___N

Does your child drink? __Bottle water ___well water ___Non-Filtered water ___Filtered city water

Does your child use fluoride toothpaste? ___Y ___N

Does your child swallow toothpaste? ___Y ___N

Brushing frequency? ___1xdaily, am ___1xdaily, pm ___2xdaily ___After each meal/snack

What type of toothbrush does your child use? ___Regular ___Electric ___Cloth ___Other

Dental flossing frequency? ___Use daily ___Occasionally ___Never

Who is responsible for tooth brushing? ___Parent ___Child ___Both

HABIT ASSESSMENT

If your child has or had any of the following oral habits, please indicate below (check all that apply):

Sucking History ___Still ___Past thumb/finger habit-stopped at ___yrs ___Never had thumb/finger habit

Was or is the habit done? ___Day & Night ___Night only ___When tired or sleepy

Grinding Teeth History ___Still ___Past grinding habit-stopped at ___yrs ___Never had grinding habit

Was or is the habit done? ___Day & Night ___Night only ___When tired or sleepy

Other Habits? ___Nail biting ___Lip biting ___Cheek and/or tongue biting ___Mouth breathing

Does your child snore? ___Y ___N

Is there any specific question / topic you would like to make sure we address while you and your child visit us?

_____

AMIGO CHILDREN'S DENTAL, P.A.
Howard H. Hunt Jr., DDS
www.amigochildrensdental.com

MEDICAL INFORMATION

Patient Name_____ **Date** _____

For the following questions, please check the appropriate answer and fill out the necessary information. Your answers are for our records only as they help us provide you with a more thorough visit and will be considered strictly confidential.

PHYSICIAN/PEDIATRICIAN INFORMATION

Pediatrician/Physician Name_____ Address_____

Phone_____ Fax_____

Please list other specialists your child may be seeing:

1. _____ Address_____ Phone:_____
2. _____ Address_____ Phone:_____

Date of last regular check-up: Date of last medical visit: Reason:

FAMILY/SIBLING HISTORY

1. Are you aware of any hereditary medical conditions from the paternal side? __Yes __No ___Don't Know
   If yes, please explain_____
2. Are you aware of any hereditary medical conditions from the maternal side? __Yes __No ___Don't Know
   If yes, please explain_____

MEDICAL NARRATIVE

1. Is your child:
   - Under the care of a doctor at the present time? __No __Yes, When?____ Why?_____
   - Taking any medications at the present time? __No __Yes, What?_____
   - Allergic to any medications? __No __Yes, What?_____
   - Allergic to any foods, materials or dyes? __No __Yes, What?_____

2. Has your child:
   - Had general anesthesia? __No __Yes
   - Had any complications with general anesthesia? __No __Yes, Explain_____
   - Had any surgeries? __No __Yes, When?_____ Why?_____
   - Ever been a patient at the Emergency Room? __No __Yes, When?_____ Why?_____
   - Ever been hospitalized as a patient? __No __Yes, When?_____ Why?_____

3. Does your child have, ever had or been diagnosed with any of the following: (please check all that apply)

___HIV+/AIDS	___Brain Surgery	___Heart problem/surgery	___Polio
___Anemia/Sickle cell trait	___Cancer-type:_____	___Hemophilia	___Pregnancy
___Allergy / Hay fever	___Chemotherapy/radiation	___Hepatitis A.B or C	___Rheumatic fever
___Arthritis / Rheumatism	___Cerebral Palsy	___High/low blood pressure	___Scarlet fever
___Artificial heart valve	___Chicken Pox	___Hormonal disturbance	___Scoliosis
___Artificial joint or limb	___Cleft Lip/palate	___Hydrocephalus	___Shunts
___Asthma	___Convulsions/seizures	___Kidney problems	__VA __VV __VP
___Attention Deficit Disorder	___Diabetes	___Leukemia	___Speech problems
___Autism	___Digestive disturbances	___Liver problems	___Surgeries
___Behavior/Learning Disabilities	___Earaches	___Malignant hyperthermia	___Syndrome:_____
___Problem learning?	___Emotional disturbances	___Measles	___Tetanus
___Problem concentrating	___Epilepsy	___Mental retardation	___Tuberculosis
___Problem cooperating	___Eye problems	___Mumps	___Venereal disease
___Problem understanding	___Fainting	___Mouth ulcers	___Whooping cough
___Bleeding disorder	___Glandular disturbance	___Nutritional disturbances	
___Birth defects	___Hearing loss/aids/implants	___Organ transplant	
___Bone/Joint/Orthopedic problems	___Heart murmur	___Pneumonia	

4. Does your child have any other disease, condition or medical problem not mentioned above? __No __Yes, Please list_____

I understand the information I have given is correct to the best of my knowledge and will be held in the strictest of confidence. I understand it is my responsibility to inform this office of any changes in my child's medical status.

SIGNED_____ **RELATIONSHIP TO CHILD**_____ **DATE**_____

AMIGO CHILDREN'S DENTAL, P.A.
Howard H. Hunt Jr., DDS

CONSENT TO DISCLOSE
PRIVATE HEALTHCARE INFORMATION
FOR TREATMENT, PAYMENT, AND/OR HEALTHCARE OPERATIONS

I, the undersigned, hereby authorize and consent for Amigo Children's Dental, P.A., and any of its associates, to release any and all medical, dental, and/or psychological reports or records of (child's name)_____, (child's date of birth)_____, including, but not limited to, medical/dental notes, physician narratives, office notes, operative notes, discharge summaries, Doctor's/Dentist's orders, Nurse's notes, lab reports, test results, physical therapy progress notes, patient progress reports, diagnosis, post-operative reports, post-operative diagnosis, pathology reports, x-rays, MRIs, any records reflecting treatment for substance abuse, mental illness, AIDS, HIV virus, alcohol abuse, including any x-rays, diagnostic studies, laboratory slides, clinical abstract, histories, charts, and other information contained therein, any documents and opinions relevant to past, present, or future physical and mental condition, treatment, care or hospitalizations, and any other personal health information regarding my medical/dental care as necessary to carry out treatment, obtain payment, and/or conduct other healthcare operations.

The release of the matters listed above is being authorized for purposes of obtaining medical/dental treatment, payment for such services and other health care operations.

A copy of this authorization is agreed by the undersigned to have the same effect and force as an original.

Any person, firm, or entity that releases matters pursuant to this authorization is hereby absolved from any liability that might otherwise result from the release of those matters.

I further understand that I have the right to review Amigo Children's Dental privacy notice and to request restrictions. I further understand that I may revoke this consent in the future if I should so desire.

Signed this _____ day of _____, 20____.

_____
Signature of Parent or Legal Guardian

_____
Printed Name of Parent or Legal Guardian

_____
Patient's Name (printed)

Special Restrictions

_____

_____

PEDIATRIC DENTISTRY INFORMED CONSENT FOR PATIENT MANAGEMENT TECHNIQUES

ACKNOWLEDGMENT OF RECEIPT OF INFORMATION

ALL IN GOOD INTENTION

It is our intent that all professional care delivered in our dental office shall be of the best possible quality we can provide for each child. We believe that any dentist can get your child's work done – our mission is to do so in a manner which leaves your child with good positive feelings about going to the dentist. The entire focus is on your child, relating to them, fostering good dental health habits and instilling a healthy, positive attitude toward dentistry for life.

All efforts will be made to obtain the cooperation of patients by the use of warmth, friendliness, persuasion, humor, charm, gentleness, kindness, and understanding. In some cases, further behavior management techniques are needed. There are several behavior management techniques that are used by pediatric dentists to gain the cooperation of patients to eliminate disruptive behavior or prevent patients from causing injury to themselves due to uncontrollable movements. These techniques are ***not*** a form of punishment and are in no way used as a form of punishment. These techniques are simply used only when and, if necessary, to complete a dental procedure in the safest manner possible.

Please read this form carefully and ask questions if you do not understand. Please initial next to each number to identify you understand the techniques we use.

PEDIATRIC DENTISTRY BEHAVIOR MANAGEMENT TECHNIQUES

_____**1. Tell-Show-Do:** The dentist or assistant explains to the patient what is to be done using simple terminology and repetition and then shows the patient what is to be done by demonstrating with instruments on a model or the patient's or dentist's finger. Then the procedure is performed in the patient's mouth as described. Praise is used to reinforce cooperative behavior.

_____**2. Positive reinforcement:** This technique rewards the patient who displays any behavior which is desirable. Rewards include compliments, praise, pat on the back, a hug, or a prize.

_____**3. Voice control:** This technique uses a controlled alteration of voice volume, tone, or pace to influence and direct the patient's behavior.

_____**4. Mouth props/Rubber dams:** A mouth prop or "tooth pillow" as we call it is used to help support the patient in keeping his/her mouth open during an operative procedure (filling, etc). This allows him/her to relax and not worry about consciously keeping his/her mouth open for the procedure. A rubber dam is a "raincoat" placed on the area of work to isolate the teeth and prevent any debris from being swallowed or going to the back of the throat.

_____**5. Immobilization by the dentist:** The dentist controls the patient from movement by gently holding down the patient's hands or upper body, stabilizing the patient's head between the dentist's arm and body.

_____**6. Immobilization by the assistant:** The assistant controls the patient from movement by gently holding the patient's hands, stabilizing the head, and/or controlling leg movements.

_____**7. Immobilization by Pedi-wrap:** A passive restraint device, designed specifically for pediatric dental procedures, that is used when complete immobilization is needed for the safety of the patient and the dental team. It is used during most, not all, sedation procedures.

_____**8. Relaxation Gas:** Nitrous oxide (laughing gas) and oxygen may be administered to relax the patient and to raise his/her pain threshold. This allows the patient to sit in the chair longer, increases their attention span, and allows for more work to be done without the patient labeling something as painful. **Nitrous oxide and oxygen is not general anesthesia.** The patient is not "put to sleep" and does not become unconscious, only relaxed.

_____**9. Conscious Sedation** is recommended for mildly apprehensive and very young patients. The majority of patients respond very well for dental treatment. For various reasons, some patients may be apprehensive about dental treatment and may require some form of conscious sedation to allow treatment.

ACKNOWLEDGMENT OF RECEIPT OF INFORMATION

1. The listed pediatric dentistry management techniques have been explained to me.
2. I am clear and understand that none of the above techniques are used in any way as punishment. These procedures are standard of care in the pediatric dental community and are merely used only if necessary to provide the best dental care.
3. I have been encouraged to ask questions and all questions about the patient management techniques described have been answered in a satisfactory manner.
4. I hereby acknowledge that I have read and understand this consent.
5. I acknowledge that I have not been coerced/ forced to sign this consent and that I have been given the alternative to withdraw from it.
6. I hereby authorize and direct Dr. Hunt assisted by other dentists and/or dental auxiliaries of her/his choice, to utilize, if required, the necessary patient management techniques to assist in the provision of the required dental treatment for my child (or legal ward).
7. I understand that this consent shall remain in effect until terminated by me.

Patient Name	Person Authorized to Consent	Relationship to Patient	Date

AMIGO CHILDREN'S DENTAL, P.A.
Howard H. Hunt Jr., DDS

CONSENT FOR TREATMENT

We are here to provide dental services to you and your child in the most beneficial way possible. This requires mutual understanding. Please read this form carefully. Should you have any questions, our business coordinators will be delighted to help you.

1. I hereby authorize and direct Dr. Howard Hunt, and/or any of his dental associates and/or dental auxiliaries to perform dental treatment with the use of any necessary or advisable radiographs (X-Rays) and/or any other diagnostic aids in order to complete a thorough diagnosis and treatment plan.

2. I understand certain parts of the treatment may be performed by certified paraprofessionals (Dental assistants/hygienists) other than the dentist.

3. I authorize Dr. Howard Hunt, and/or any of his dental associates and/or dental auxiliaries to take and to use photographs, radiographs, other diagnostic materials, and treatment records for the purposes of teaching, research, and scientific publication. The photographs shall be used for dental records and if in the judgment of Dr. Hunt and/or any of his dental associates, dental research, education, or science will be benefited by their use, such photographs and information relating to my child's case may be published and republished, either separately or in connection with each other, in professional journals or medical books, or used for any other purpose which s/he may deem proper in the interest of medical education, knowledge, or research; provided, however, that it is specifically understood that in any such publication or use my name or my child's name not be identified by name. The aforementioned photographs may be modified or retouched in any way that my dentist, in his/her discretion, may consider desirable.

4. I understand x-rays, photographs, models of the mouth, and/or any other diagnostic aid used for an accurate diagnosis and treatment planning are the property of the doctor but copies are available upon request for a fee.

5. In general terms, the dental procedure(s) can include but not be limited to:
   A. Comprehensive oral examination, radiographs, cleaning of the teeth, and the application of topical fluoride.
   B. Application of plastic "sealants" to the grooves of teeth.
   C. Treatment of diseased or injured teeth with dental restorations (fillings), stainless steel or composite crowns, and/or root canal treatment.
   D. Oral surgery: Extraction of one or more teeth, excision of hyper plastic and/or pericoronal tissue, frenectomy, exposure of unerupted tooth.
   E. Placement of space maintainers and/or replacement of missing teeth with dental prosthesis.
   F. Treatment of diseased or injured oral tissues secondary to traumatic injuries and/or accidents and/or infection.
   G. Treatment of habits, malposed (crooked) teeth, orthodontia and/or oral, dental developmental or growth abnormalities.
   H. Recommendation for treatment to be completed using conscious sedation or general anesthesia.

6. I understand that the doctor is not responsible for previous dental treatment. I understand that, in the course of treatment, this previously existing dentistry may need adjustment and/or replacement.

7. I realize that guarantees of results or absolute satisfaction are not possible in dental health service.

8. I have answered all the questions about my or my dependent's medical history and present health condition fully and truthfully. I have told the dentist or other office personnel about all conditions, including allergies, which might indicate that my child should not receive oral medications and/or antianxiety agents. I also understand if I or my dependent ever had any changes in health status or any changes in medication(s), I will inform the doctor at the next appointment.

9. I authorize Dr. Howard Hunt and/or any of his dental associates to forward a review of findings and/or any other dental information to the referring doctor (if such has been the referral source) or any other health care giver for his/her records, as well as any third parties such as insurance companies who may request information.

I hereby acknowledge that I have read and understand this consent and the meaning of its contents. All questions have been answered in a satisfactory manner and I believe I have sufficient information to give this informed consent. I further understand that this consent shall remain in effect until terminated by me.

Patient Name	Person Authorized to Consent	Relationship to Patient	Date

AMIGO CHILDREN'S DENTAL, P.A.
Howard H. Hunt Jr., DDS

PARENT-DENTIST COMMITMENT

We believe good communication, understanding and respect are the basis for an admirable, worthy relationship. Because we strongly believe in our work and professional efforts and hold the relationship we develop with our patients and parents so highly, we ask that you read this document thoroughly. We ask you to sign the Parent-Dentist Commitment indicating you understand its contents and agree to honor them.
The ultimate goal of Amigo Children's Dental, P.A. is to provide the best standard of care to and be understanding of all our patients. We feel confident in our ability to provide you and your child valuable dental care that will exceed all your expectations. Our desire is to establish a long-lasting relationship with you and your child.

Our financial policy is:
We require payment in full at the time service is rendered. We accept MasterCard, Visa, Discover, American Express, check, money order or cash. We also offer payment plans using our in house financing program – Care Credit. Should any check be returned for insufficient funds, a $35 return check fee will be applied to your account. If you have dental insurance, it is our pleasure to assist you in maximizing your insurance benefits by filing your claims with your insurance company. It is important that you understand that as your dental care provider, our relationship is with you, not your insurance company. The range of benefits depends solely on what your employer wishes to purchase. We will give you an estimated co-payment amount which is to be paid on the day of service. If a credit appears on your account once the carrier has benefited the claim, a refund will be issued to you. Likewise, if any outstanding balance remains on your account once the carrier has benefited the claim, a statement will be sent to you for immediate payment. If for any reason, we have not received your insurance carrier's payment 60 days after the filing of the claim, the remaining balance will be due and payable by you. A $3 processing fee for any statements sent past the 60 day limit will also be incurred.

You may receive a notification from your insurance company stating that dental fees are higher than "usual and customary". Insurance companies never reveal how they determine "usual, customary, and reasonable" (UCR) fees. They are at least determined by taking some percentage of an average fee for a particular procedure in a geographic area. Average has been defined as "The worst of the best" or "The best of the worst". ***We do not provide average dentistry nor do we charge below average fees.***

The parent or guardian who brings the child to our office is responsible for payment in full. All statements will be sent to this individual. We will not bill a third party other than insurance companies.

If you have any concerns regarding the financial portion of any treatment plan, please discuss these issues with our treatment coordinator prior to starting treatment. We will not alter our normal financial arrangements once treatment has been done.

Our Cancellation Policy is to bring the highest level of service to our entire patient population. In order to do this we maintain a strict respect for your time and strive to see all of our patients at their appointed times. We know you respect this and strive for the same. At times we have a "waiting list" of patients wanting earlier appointments than we are able to provide. Subsequently, we request 48 hours of notice if you need to change your appointment for any reason. Cancellations provided with less than 48 hours notice may result in a $50 cancellation fee being applied to your account and a pre-payment by you to schedule the next appointment. To assist you in your appointments, we will confirm each upcoming appointment one week in advance with a reminder 2 days prior to the appointment date. It is important that you confirm these calls with us. Failure to do so may result in the cancellation of your appointment. This policy enables us to accommodate as many needs as possible by offering the cancelled/unconfirmed appointment to others. ***We reserve the right to dismiss a patient from our practice due to multiple cancellations and/or missed appointments without proper notice.***

- I have read the above internal policies and understand my financial options and obligation as well as the cancellation policy as described.

_____

Signature of parent/legal guardian Date

AMIGO CHILDREN'S DENTAL, P.A.

NOTICE OF PRIVACY PRACTICES (DENTAL)

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA," we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of June, 2009 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint. Please contact us for more information.

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
Tel: 202-619-0257
Toll Free: 877-696-6775

Date: _____ Signature: _____

Patient Name: _____