PREMIER SURGICAL ASSOCIATES

updated 10/12/22

PATIENT INFORMATION FORM (PLEASE PRINT AND USE BLACK INK)

Date: _____ Pt#_____

Patient Name *(First, Middle, Last)* _____ **Sex:** M F *(circle one)*

Social Security No. _____ **Date of Birth** _____

Race: *(circle one)* C/W, H/L, B, O**,** Not Reported/Refused **Ethnicity:** *(circle one)* C/W, H/L, B, O, Not Reported/Refused

Language: _____ **Marital Status:** (*circle one)* S, M, D, W, Legally Separated

Employment Status: *(circle one)* Employed , Unemployed, Self Employed, Disabled, Retired, F/T Student, P/T Student

Employer _____ **Occupation** _____

SNF Are you currently in a Skilled Nursing Facility? Y N (circle one) If so, name of **SNF**_____

Patient Mailing Address _____ **City** _____ **State** _____ **Zip** _____

E-mail Address _____

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

By including your cell phone number, you give Premier consent to call your cell phone for automated appointment reminders

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Referring Physician *(Include Phone No.)* _____

Other *Current* Physicians on Your Care Team *(Include Phone No.)*

Primary Care*(PCP)* _____ **Other** _____

Cardiology _____ **Gastro**_____

Pulmonary _____ **Endocrinology** _____

Nephrology _____ **Dialysis Center** _____

YOUR LOCAL PHARMACY ONLY

Preferred Pharmacy _____ **Phone No.** _____

Pharmacy Address _____ **City** _____ **State** _____ **Zip** _____

EMERGENCY CONTACT INFORMATION

Contact Name *(First, MI, Last)* _____ **Sex:** M F *(circle one)*

Relationship to the Patient:_____ **Language:** _____

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

Contact is a Parent/Guardian: Y N *(circle one)* If patient is under the age of 18, Emergency Contact **should** be a Parent or Guardian unless patient is an Emancipated Minor.

INSURANCE INFORMATION

PRIMARY Insurance Company

Ins. Co. Name_____ **Group No.** _____ **Member ID** _____ **Specialist Co-pay** $_____

Primary Insurance Subscriber:_____ **Relationship to the Patient**_____

Subscriber's Social Security No. _____ **Subscriber's Date of Birth** _____

Subscriber's Address *(if different from patient)* _____**City** _____**State** _____**Zip** _____

Subscriber's Home Phone _____ **Work Phone** _____ **Cell Phone** _____

Subscriber's Marital Status: (circle one) S, M, D, W, Legally Separated **Sex:** M F

Employment Status:_____ **Subscriber's Employer** _____

SECONDARY Insurance Company

Ins. Co. Name_____ **Group No.** _____ **Member ID** _____

Secondary Insurance Subscriber:_____ **Relationship to the Patient:**_____

Subscriber's Social Security No. _____ **Subscriber's Date of Birth** _____

Subscriber's Address *(if different from patient)* _____**City** _____**State** _____**Zip** _____

Subscriber's Home Phone _____ **Work Phone** _____ **Cell Phone** _____

Subscriber's Marital Status: (circle one) S, M, D, W, Legally Separated **Sex:** M F

Employment Status:_____ **Subscriber's Employer:**_____

WORKERS COMPENSATION or AUTO INSURANCE INFORMATION

Your Supervisor _____ **Supervisor's Phone No.** _____

Workers Compensation or Auto Insurance Phone No. _____

Claims Address _____ **City** _____ **State** _____ **Zip** _____

Adjuster's Name _____**Adjuster's Phone No.** _____

Claim No. _____ **Approval No.** _____

Date od Injury _____ **Did injury occur at work:** Y N *(circle one)* **Auto Accident:** Y N *(circle one)*

Briefly describe injury or accident _____

Do you have any of the following: *(circle all that apply)* Living Will, Do Not Resuscitate *(DNR)*, Power of Attorney *(POA)*, End of Life Decision, No Cardio-Pulmonary Resuscitation *(CPR)*, None

PREMIER
Surgical
Expertise You Can Trust

PREMIER SURGICAL ASSOCIATES, PLLC

PLEASE READ

All charges are due at the time of service. If hospitalization or surgery is indicated, we will file your claim directly to your insurance company. Please remember that most insurance companies do not pay the full amount, and therefore, you are responsible for the balance. If there is a problem paying the balance in full, please let us know and we will be happy to work with you.

FINANCIAL RESPONSIBILITY

(Financial Policy is available in office UPON REQUEST)

I understand and commit to the following:

1. I have received a copy of Premier's financial policies and have read and understand these policies.
2. I will pay my co-pay, deductible and co-insurance at the time of service.
3. I will provide the most current insurance information and immediately notify Premier of changes.
4. If surgery is required, all or a portion of my financial responsibility must be paid prior to surgery.
5. I will follow my insurance company's requirements for referrals and pre-authorizations and I understand that if I fail to do so, my insurance benefits will be reduced and I will be responsible for all denied balances.
6. I understand that I am responsible for all balances.
7. If I have no insurance, I have informed Premier and I am responsible for 100% of all balances.
8. A collection fee of 30% will be added to all my accounts that are turned over to collection agencies.

INSURANCE AUTHORIZATION AND RELEASE

I request that payment of authorized benefits – including Medicare, and any other government sponsored program, private insurance, and any other health plans – be made to **Premier Surgical Associates, PLLC** for any services furnished by that provider. I authorize any holder of medical information about me to release to those persons or companies presenting a legitimate request for such information needed to determine these benefits or the benefits payable for related services. I authorize **Premier Surgical Associates, PLLC** to act as my agent to help me obtain any required pre-certification as well as acting as my agent to help me obtain payment from mu insurance companies. I authorize my insurance companies to give **Premier Surgical Associates, PLLC** any information they require to fulfill this function. This will remain in effect until revoked in writing. A photocopy of this assignment and release is to be considered as valid as the original.

Patient's Signature X _____**Date**_____

MISSED APPOINTMENT POLICY

In order to provide the best care and service to our patients, we ask that you notify us 24 hours in advance to cancel and/or reschedule your office visit, ultrasound or other diagnostic test appointment. A minimum of 30 and up to 90 minutes is set aside for each appointment and your communication and compliance is much appreciated by your physician and supporting staff.
Please be aware that if 24 hour notice is not received a fee of $25 may be charged to your account which must be settled before another appointment is scheduled.
Please call us if you are unable to keep your scheduled appointment. This will provide us an opportunity to reschedule your appointment to a more convenient time and avoid any additional charges on your account.

Patient's Signature X _____ **Date**_____

HIPAA FORM

updated 8/30/22

Limited Patient Authorization for Disclosure of Protected Health Information

Form 7.31

Please print all information. Form must be signed and dated.

Patient Name: _____

Date of Birth: _____

SSN (last 4 digits)_____

Entity Requested to Release Information: _____

Who will be authorized to receive information - I authorize the entity identified above to disclose or provide protected health information about me to the individual/entity listed below:

Individual/Entity Name: _____

Address: _____

Phone/Fax*: _____/_____

Email *: _____

* **Secure Communication** - Note that some fax and email transmission methods are not secure, and it is possible for your PHI to be compromised during transmission from our practice. Do not include a recipient fax number or email address if this is of concern to you.

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ Entire patient record; **or**, check **only** those items of the record to be disclosed:

- ☐ office notes
- ☐ lab results, pathology reports
- ☐ x-rays
- ☐ financial history report
- ☐ nursing home, home health, hospice, and other physician records
- ☐ record of HIV and communicable disease testing
- ☐ record of mental health or substance abuse treatment
- ☐ Only disclose the following: _____

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

☐ Patient Request ☐ Other (please specify): _____

- This authorization will expire at the end of the calendar year, unless you specify an earlier termination. You must submit a new authorization form after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: _____
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

_____

PATIENT SIGNATURE DATE

Notice of Privacy Practices
Premier Surgical Associates, PLLC

Patient Name:_____ DOB:_____

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule
Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location within the practice, and if such is maintained by the practice, on it's web site.

You have the right to authorize other use and disclosure - This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and copy your PHI - This means you may inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines.

You have the right to request a restriction of your PHI - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You may have the right to request an amendment to your protected health information - This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability - This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

If you have questions regarding your privacy rights, please feel free to contact our Privacy Manager. Contact information is provided on the following page under Privacy Complaints.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office, for fund-raising activities, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Health Information Organization - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of the PHI, then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures - We are also permitted to use or disclose your PHI without your written authorization for the following purposes: as required by law; for public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security; worker's compensation; when an inmate in a correctional facility; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying the Privacy Manager at:

Address: Premier Surgical Associates, ATTN: Privacy Manager, 6408 Papermill Drive, Suite 220, Knoxville, TN 37919
Phone: 865-8-306-5700

We will not retaliate against you for filing a complaint.

Patient Signature:_____Date:_____

Effective Date May 16, 2013 Publication Date October 6, 2016

PATIENT'S NAME: _____ **DOB:** _____ **AGE:** _____

DATE: _____ **REASON FOR VISIT:** _____

Patient's Past Medical History

☐ No prior serious illness

Endocrine

Y ☐ N ☐ Diabetes
Y ☐ N ☐ Thyroid Disease
Y ☐ N ☐ High Cholesterol

Eyes

Y ☐ N ☐ Glaucoma
Y ☐ N ☐ Legally Blind

Cardiovascular

Y ☐ N ☐ High Blood Pressure
Y ☐ N ☐ Congestive Heart Failure
Y ☐ N ☐ Prior Heart Attack
Y ☐ N ☐ Coronary Heart Disease
Y ☐ N ☐ Previous Hospitalization for Cardiac problem
Y ☐ N ☐ Cardiac Catheterization
Y ☐ N ☐ Non Healing Wound

Respiratory

Y ☐ N ☐ Asthma
Y ☐ N ☐ Emphysema
Y ☐ N ☐ Bronchitis
Y ☐ N ☐ Pneumonia
Y ☐ N ☐ Tuberculosis
Y ☐ N ☐ Shortness of Breath
Y ☐ N ☐ Sleep Apnea

Gastrointestinal

Y ☐ N ☐ Diverticulitis of Colon
Y ☐ N ☐ Colonic Diverticulosis
Y ☐ N ☐ GERD
Y ☐ N ☐ Colon Cancer
Y ☐ N ☐ Hepatitis
Y ☐ N ☐ Cirrhosis
Y ☐ N ☐ Ulcerative Colitis
Y ☐ N ☐ Crohn's Disease
Y ☐ N ☐ Hiatal Hernia
Y ☐ N ☐ Irritable Bowel Syndrome

Genitourinary

Y ☐ N ☐ Dialysis
Y ☐ N ☐ Kidney Stones
Y ☐ N ☐ Prostate Disorders
Y ☐ N ☐ Renal Failure
Y ☐ N ☐ End Stage Renal Disease
Y ☐ N ☐ Renal Dialysis

Musculoskeletal

Y ☐ N ☐ Arthritis
Y ☐ N ☐ Gout
Y ☐ N ☐ Lupus
Y ☐ N ☐ Fibromyalgia

Breast

Y ☐ N ☐ Breast Cancer
Y ☐ N ☐ Skin Cancer
Y ☐ N ☐ Scleroderma

Neurologic

Y ☐ N ☐ Stroke Syndrome
Y ☐ N ☐ Seizure Disorder
Y ☐ N ☐ Brain Aneurysm
Y ☐ N ☐ Neuropathy (weakness hands/feet)

Hematologic/Lymph

Y ☐ N ☐ Blood Clots
Y ☐ N ☐ Anemia
Y ☐ N ☐ HIV
Y ☐ N ☐ Hodgkin's Disease
Y ☐ N ☐ Leukemia
Y ☐ N ☐ Lymphoma

Social History

Y ☐ N ☐ Alcohol Use
Y ☐ N ☐ Caffeine Use
Y ☐ N ☐ Recreational Drug Use

M=Mother, F=Father, B=Brother, S=Sister, GM/GF=Grandmother/Father

Family History			M, F, B, S	GM/GF
Y ☐	N ☐	Heart Disease		
Y ☐	N ☐	High Blood Pressure		
Y ☐	N ☐	Diabetes		
Y ☐	N ☐	Stroke Syndrome		
Y ☐	N ☐	Colon Cancer		
Y ☐	N ☐	Breast Cancer		

Past Surgical History

Arterial Surgery

Y ☐ N ☐ Aneurysm Repair (AAA)
Y ☐ N ☐ Previous Coronary Artery Bypass
Y ☐ N ☐ Atherosclerosis of Bypass Graft of the extremities (Leg/Bypass)
Y ☐ N ☐ Peripheral Stent (Leg/Trunk Stent)

_____ _____

Physician's signature Date

PATIENT'S NAME: _____ **DOB:** _____

Past Surgical History (cont)

Musculoskeletal Surgery

- Y ☐ N ☐ Back Surgery
- Y ☐ N ☐ Total Hip Replacement
- Y ☐ N ☐ Knee Replacement
- Y ☐ N ☐ Rotator Cuff Repair
- Y ☐ N ☐ Fracture

Gastrointestinal Surgery

- Y ☐ N ☐ Appendectomy
- Y ☐ N ☐ Gallbladder Surgery
- Y ☐ N ☐ Partial Colectomy (colon resection)
- Y ☐ N ☐ Colostomy
- Y ☐ N ☐ Ileostomy
- Y ☐ N ☐ Hemorrhoidectomy
- Y ☐ N ☐ Small Bowel Resection
- Y ☐ N ☐ Splenectomy
- Y ☐ N ☐ Pancreatectomy
- Y ☐ N ☐ Stomach Ulcer Surgery

Head & Neck Surgery

- Y ☐ N ☐ Thyroid Surgery
- Y ☐ N ☐ Parathyroid Surgery
- Y ☐ N ☐ Carotid Surgery or Stent
- Y ☐ N ☐ Tonsillectomy/Adenoidectomy

Cardiac/Thoracic Surgery

- Y ☐ N ☐ Heart Valve Replacement
- Y ☐ N ☐ Heart Bypass (CABG)
- Y ☐ N ☐ Cardiac Pacemaker Placement
- Y ☐ N ☐ Cardioverter-Defibrillator
- Y ☐ N ☐ Heart Stent Placement
- Y ☐ N ☐ Lung Surgery

Genitourinary Surgery

- Y ☐ N ☐ Nephrectomy
- Y ☐ N ☐ Lithotripsy
- Y ☐ N ☐ Prostate Surgery

Hernia Surgery

- Y ☐ N ☐ Inguinal Hernia Repair (Groin)
- Y ☐ N ☐ Umbilical Hernia Repair (Navel)
- Y ☐ N ☐ Femoral Hernia Repair
- Y ☐ N ☐ Incisional Hernia Repair
- Y ☐ N ☐ Ventral Hernia Repair (Abdominal)

Female Surgery

- Y ☐ N ☐ Breast Surgery
- Y ☐ N ☐ Hysterectomy
- Y ☐ N ☐ Tubal Ligation
- Y ☐ N ☐ Cesarean Surgery

Other Surgeries

- Y ☐ N ☐ Craniotomy
- Y ☐ N ☐ Temporal Artery Biopsy
- Y ☐ N ☐ Cataract Surgery

Review of Systems (Current Symptoms)

Constitutional

- Y ☐ N ☐ Recent Weight Gain of _____ lbs
- Y ☐ N ☐ Recent Weight Loss of _____ lbs
- Y ☐ N ☐ Fever (as a symptom)

Eyes

- Y ☐ N ☐ Pain in or around Eyes
- Y ☐ N ☐ Vision Problems

ENMT

- Y ☐ N ☐ Loss of Hearing
- Y ☐ N ☐ Bleeding Gums

Cardiovascular

- Y ☐ N ☐ Chest Pain or Discomfort
- Y ☐ N ☐ Heart Rate is Fast
- Y ☐ N ☐ Chest Pain when climbing stairs

Respiratory

- Y ☐ N ☐ Cough
- Y ☐ N ☐ Shortness of Breath

Gastrointestinal

- Y ☐ N ☐ Black or Bloody Stools
- Y ☐ N ☐ Yellow Skin or Eyes (Jaundice)
- Y ☐ N ☐ Nausea
- Y ☐ N ☐ Vomitting
- Y ☐ N ☐ Constipation
- Y ☐ N ☐ Diarrhea
- Y ☐ N ☐ Abdominal Pain
- Y ☐ N ☐ GERD

Genitourinary

- Y ☐ N ☐ Blood in Urine
- Y ☐ N ☐ Urinary Frequency
- Y ☐ N ☐ Pain During Urination

Date of last Mammogram_____ Never (circle)

Date of last Colonoscopy_____ Never (circle)

Musculoskeletal

- Y ☐ N ☐ Leg Pain with Exercise
- Y ☐ N ☐ Localized Soft Tissue Swelling of the Leg

Psychiatric

- Y ☐ N ☐ Depression
- Y ☐ N ☐ Anxiety
- Y ☐ N ☐ Memory Lapses or loss

Skin/Breast

- Y ☐ N ☐ Breast Lump ____ Right ____ Left
- Y ☐ N ☐ Breast Pain ____ Right ____ Left
- Y ☐ N ☐ Skin Lesions
- Y ☐ N ☐ Skin Rash

Neurologic

- Y ☐ N ☐ Dizziness
- Y ☐ N ☐ Confusion

_____ _____

Physician's signature Date

PATIENT'S NAME: _____ **DOB:** _____

Hematologic/Lymph

Y☐ N☐ Easy Bleeding
Y☐ N☐ Easy Bruising Tendency
Y☐ N☐ Swollen Glands in the Neck
Y☐ N☐ Groin Lymph Nodes Swelling

Other

Y☐ N☐ Patient believes she is pregnant
Y☐ N☐ Periods of not breathing while asleep
___Never Smoked ___ Former Smoker ___ Current Smoker

Y☐ N☐ Flu Vaccine
Y☐ N☐ Pneumococcal Vaccine
Y☐ N☐ PTCA, if so what year _____

CURRENT MEDICATIONS

NAME OF MEDICATION	DOSAGE (mg, tsp, etc)	HOW MANY TIMES PER DAY

ALLERGIES

MEDICATION YOU ARE ALLERGIC TO:	REACTION YOU HAVE:

Y☐ N☐ ALLEGRIC TO LATEX
Y☐ N☐ HAVE YOU BEEN PRESCRIBED A NARCOTIC/PAIN MEDICATION BY ANOTHER MD IN THE LAST 30 DAYS?
Y☐ N☐ ARE YOU CURRNETLY ENROLLED IN A PAIN MANAGEMENT CLINIC?

HEIGHT: _____ **WEIGHT:** _____

******PLEASE GIVE THIS FORM TO THE RECEPTIONIST AS SOON AS YOU COMPLETE IT.**

_____ _____
Physician's signature Date