

CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____ First Name _____ Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex M F Age _____

Birthdate _____

Married Widowed Single Minor

Separated Divorced Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

Employer/School Phone (____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE
 I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to _____
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date _____ Relationship to Patient

3 PHONE NUMBERS

Cell Phone (____) _____ Home Phone (____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (____) _____ Work Phone (____) _____

4 ACCIDENT INFORMATION

Is condition due to an accident? Yes No Date _____

Type of accident Auto Work Home Other

To whom have you made a report of your accident?
 Auto Insurance Employer Worker Comp. Other

Attorney Name (if applicable) _____

5 PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? Yes No Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

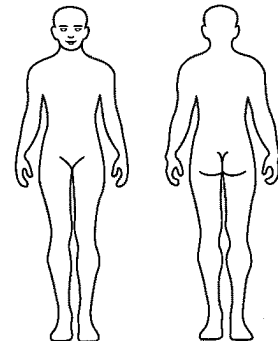
Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps Stiffness Swelling Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform Sitting Standing Walking Bending Lying Down



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HEALTH HISTORY

What treatment have you already received for your condition? Medications Surgery Physical Therapy

Chiropractic Services None Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy Shots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sexually Transmitted Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Suicide Attempt	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Goiter	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gonorrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors, Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lump	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Typhoid Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched Nerve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bulimia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Disk	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No	Whooping Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____	
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No		

EXERCISE

- None
 Moderate
 Daily
 Heavy

WORK ACTIVITY

- Sitting
 Standing
 Light Labor
 Heavy Labor

HABITS

- Smoking Packs/Day _____
 Alcohol Drinks/Week _____
 Coffee/Caffeine Drinks Cups/Day _____
 High Stress Level Reason _____

Are you pregnant? Yes No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

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MEDICATIONS

ALLERGIES

VITAMINS/HERBS/MINERALS

Pharmacy Name _____

Pharmacy Phone (____) _____

Center Street Chiropractic, LLC

Patient Name: _____
 Date: _____

E-MAIL _____
 SS# _____

Hospitalizations/Major Illness	Date

Smoking Status	Yes Or No	How many per/day	How many years	When did you quit?
Never Smoked				
Current Smoker				
Former Smoker				

Past Surgery	Date

Height	Weight

Medication/Vitamin (Include over-the-counter/Vitamins)	Date Started	Dose	Times per Day

Family History	Mother	Father	Sister	Brother	Maternal Grand Parents	Paternal Grand Parents
Cancer						
Diabetes						
Heart Disease						
Heart Failure						
High Blood Pressure						
Kidney Disease						
Stroke						
Living						
Deceased						

Allergies:
Immunizations:

In order to comply with federal regulations, we are required to ask you to provide the following information:

RACE	ETHNICITY
<input type="checkbox"/> White/Caucasian	<input type="checkbox"/> Hispanic or Latino
<input type="checkbox"/> African American	<input type="checkbox"/> Not Hispanic or Latino
<input type="checkbox"/> Asian	<input type="checkbox"/> Unknown/Unreported
<input type="checkbox"/> Hispanic	
<input type="checkbox"/> Other	
<input type="checkbox"/> I prefer not to disclose	

Have you ever been diagnosed with:
 Hypertension **YES/NO** Diabetes **YES/NO**

Primary Language:
 English
 Spanish
 Other _____

Patient Financial Policy
Dr. Kevin Drumbore
Center Street Chiropractic • 19 Center Street • Chatham, NJ 07928
973-635-3100

Thank you for choosing our office as your healthcare provider. We are committed to making your treatment successful. You are required to read and sign the following office financial policy prior to the commencement of any treatment.

Your insurance plan is an agreement between you and your insurance carrier. We are not party to that contract. You are responsible to know your policy. You are responsible for your deductibles, coinsurance and co-pays. Your balance will become your responsibility if denied by your carrier for any reason. You reserve the right to appeal the reimbursement for services or lack of with your carrier pursuant to your health care insurance contract.

Please be aware that some and perhaps all services which we provide may be considered uncovered services, and therefore considered not medically necessary under the Medicare program and other insurance carriers.

You hereby further provide **Center Street Chiropractic, LLC/Kevin Drumbore** with a limited, irrevocable power of attorney to endorse any checks or other negotiable instruments made payable to you individually for services rendered by Center Street Chiropractic, LLC/Kevin Drumbore or jointly to you and **Center Street Chiropractic, LLC/Kevin Drumbore**. This power expressly authorizes third parties including but not limited to commercial banking institutions to honor our endorsement on your behalf under this power of attorney and to accept deposit or cashing of any such negotiable instrument. This limited power of attorney shall be immediately effective and shall be durable in that it shall remain in full effect through any disability of the principal granting this power of attorney.

If your insurance plan requires a referral prior to the commencement of treatment, it is your responsibility to have one prior to the commencement of examination or treatment.

Our office plans an extensive portion of time to spend with you on each visit. Canceling or "no showing" causes a loss of this time, which could have been used to see other patients. We ask that you make every effort to keep your scheduled appointment. We reserve the right to charge you for the missed visit. This will not be covered by any insurance company. We ask that you please be considerate and help us to serve you better by keeping scheduled appointments.

THIS FINANCIAL AGREEMENT IS A VALID CONTRACT BETWEEN THE PATIENT AND HEALTH CARE PROVIDER. I CERTIFY THAT I HAVE READ THE ABOVE INFORMATION, OR THAT THE INFORMATION HAS BEEN READ OR TRANSLATED TO ME, AND THAT I UNDERSTAND MY RIGHTS AND OBLIGATIONS AS A PATIENT UNDER THIS AGREEMENT.

Patient Name, (Printed)

Witness:

Signature

Date

FEE SCHEDULE

New Patient Examination	\$ 250.00
Re-Exam	\$ 35.00
Spinal Adjustment	\$ 70.00
Medicare Spinal Adjustment:	
1 -2 Regions	\$ 34.36
3- 4 Regions	\$ 49.15
5 Regions	\$ 63.92
Extremity Adjustment	\$ 25.00
Therapy (Ultra Sound, Electrical Stim)	\$ 30.00
Maintenance Adjustment	\$ 60.00 w/therapy \$ 80.00
(non-reimbursable by insurance)	

Low Back Pain and Disability Questionnaire (Revised Oswestry)

Patient Name: _____ Date: _____ Score: _____

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the **ONE** box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

➤ Section 1- PAIN INTENSITY

- The pain comes and goes and is very mild.
- The pain is mild and does not vary much.
- The pain comes and goes and is moderate.
- The pain is moderate and does not vary much.
- The pain comes and goes and is severe.
- The pain is severe and does not vary much.

➤ Section 2- PERSONAL CARE

- I would not have to change my way of washing or dressing in order to avoid pain.
- I do not normally change my way of washing or dressing even though it causes some pain.
- Washing and dressing increase the pain but I manage not to change my way of doing it.
- Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- Because of the pain I am unable to do some washing and dressing without help.
- Because of the pain I am unable to do any washing and dressing without help.

➤ Section 3-LIFTING

- I can lift heavy weights without extra pain.
- I can lift heavy weight but it causes extra pain.
- Pain prevents me from lifting heavy weights off the floor
- Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned (e.g.: on the table).
- Pain prevents me from lifting heavy weight but I can manage light to medium weights if they are conveniently positioned.
- I can only lift very light weights at the most.

➤ Section 4-WALKING

- I have no pain while walking.
- I have some pain while walking but it does not increase with distance.
- I cannot walk more than one mile without increasing pain.
- I cannot walk more than $\frac{1}{2}$ of a mile without increasing pain.
- I cannot walk more than $\frac{1}{4}$ of a mile without increasing pain.
- I cannot walk at all without increasing pain.

➤ Section 5-SITTING

- I can sit in any chair as long as I like.
- I can only sit in my favorite chair as long as I like.
- Pain prevents me from sitting more than one hour.
- Pain prevents me from sitting more than a half hour.
- Pain prevents me from sitting more than 10 minutes.
- I avoid sitting because it increases pain straight away.

Please flip over and complete the
second part of questionnaire

➤ **Section 6-STANDING**

- I can stand as long as I want without pain.
- I have some pain on standing but it does not increase with time.
- I cannot stand for longer than one hour without increasing pain.
- I cannot stand for longer than a ½ hour without increasing pain.
- I cannot stand for longer than 10 minutes without increasing pain.
- I avoid standing because it increases the pain straight away.

➤ **Section 7-SLEEPING**

- I get no pain in bed.
- I get pain in bed but it does not prevent me from sleeping well.
- Because of pain my normal night's sleep is reduced by ¼.
- Because of pain my normal night's sleep is reduced by ½.
- Because of pain my normal night's sleep is reduced by ¾.
- Pain prevents me from sleeping at all.

➤ **Section 8- SOCIAL LIFE**

- My social life is normal and gives me no pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interest, e.g. dancing etc.
- Pain has restricted my social life and I do not go out often.
- Pain has restricted my social life to my home.
- I hardly have any social life because of the pain.

➤ **Section 9- TRAVELLING**

- I get no pain while travelling.
- I get some pain while travelling but none of my usual forms of travel make it any worse.
- I get extra pain while travelling but it does not compel me to seek alternative forms of travel.
- I get extra pain while travelling which compels me to seek alternative forms of travel.
- Pain restricts all forms of travel.
- Pain prevents all forms of travel except that done lying down.

➤ **Section 10-CHANGING DEGREE OF PAIN**

- My pain is rapidly getting better.
- My pain fluctuates but overall is definitely getting better.
- My pain seems to be getting better but improvements is slow at present.
- My pain is neither getting better or worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

➤ **Pain Severity Scale:**

Rate the severity of your pain by circling one of the numbers on the following scale:

No Pain

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Excruciating Pain

Neck Pain and Disability Index (Vernon-Minor)

Patient Name: _____ Date: _____ Score: _____

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the **ONE** box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

➤ Section 1- PAIN INTENSITY

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

➤ Section 2- PERSONAL CARE (Washing, Dressing, etc.)

- I can look after myself normally without causing extra pain.
- I can look after myself normally but it causes extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help but manage most my personal care.
- I need help every day in most aspects of self care.
- I do not get dressed, I wash with difficulty and stay in bed.

➤ Section 3-LIFTING

- I can lift heavy weights without extra pain.
- I can lift heavy weight but it causes extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g.: on the table).
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift very light weights.
- I cannot lift or carry anything at all.

➤ Section 4-READING

- I can read as much as I want to with no pain in my neck.
- I can read as much as I want to with a slight pain in my neck.
- I can read as much as I want to with moderate pain in my neck.
- I can't read as much as I want to because of moderate pain in my neck.
- I can hardly read at all because of severe pain in my neck.
- I cannot read at all.

➤ Section 5-HEADACHES

- I have no headaches at all.
- I have slight headaches which come infrequently.
- I have moderate headaches which come infrequently.
- I have moderate headaches which come frequently.
- I have severe headaches which come frequently.
- I have headaches almost all the time.

Please flip over and complete the
second part of questionnaire

➤ **Section 6-CONCENTRATION**

- I can concentrate fully when I want with no difficulty.
- I can concentrate fully when I want to with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty concentrating when I want to.
- I cannot concentrate at all.

➤ **Section 7-WORK**

- I can do as much work as I want to.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I can't do any work at all.

➤ **Section 8- DRIVING**

- I can drive my car without any neck pain.
- I can drive my car as long as I want with slight neck pain.
- I can drive my car as long as I want with moderate neck pain.
- I can't drive my car as long as I want because of moderate neck pain
- I can hardly drive at all because of severe pain in my neck.
- I can't drive my car at all.

➤ **Section 9- SLEEPING**

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hr. sleepless)
- My sleep is mildly disturbed (1-2 hrs. sleepless)
- My sleep is moderately disturbed (2-3hrs. sleepless)
- My sleep is greatly disturbed (3-5 hrs. sleepless)
- My sleep is completely disturbed (5-7 hrs. sleepless)

➤ **Section 10-RECREATION**

- I am able to engage in all my recreational activities with no neck pain at all.
- I am able to engage in all my recreational activities with some pain in my neck.
- I am able to engage in most, but not all my usual recreational activities because of pain in my neck.
- I am able to engage in a few of my usual recreational activities because of pain in my neck.
- I can hardly do any recreational activities because of pain in my neck
- I can't do any recreational activities at all.

➤ **Pain Severity Scale:**

Rate the severity of your pain by circling one of the numbers on the following scale:

No Pain

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Excruciating Pain

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

Dr. Kevin Drumbore
Center Street Chiropractic • 19 Center Street • Chatham, NJ 07928
973-635-3100

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, physio therapy, physical medicine, physical therapy procedures, etc. on me by the doctor of chiropractic named above and/or other assistants.

I understand, as with any health care procedures, that there are certain complications which may arise during chiropractic treatments. Those complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strain, Horner’s syndrome, diaphragmatic paralysis, cervical myelopathy, and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the then known facts, that are in my best interest.

I have had an opportunity to discuss the nature, purpose, and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE

Printed name of Patient

X _____
Signature of Patient

Date

X _____
Signature of Representative
(If patient is a minor or is handicapped)

Date

X _____
Witness to Patient’s Signature

Date

INFORMED CONSENT FOR NUTRITIONAL COUNSELING

Dr. Kevin Drumbore
Center Street Chiropractic • 19 Center Street • Chatham, NJ 07928
973-635-3100

During the course of your treatment Dr. Drumbore may provide, as an extra benefit to you, a nutritional assessment or nutritional guidance. This is provided to you in order to support your body, improve your overall health, or speed the healing process. The advice given is general in nature and is not intended to treat a specific disease or symptom.

Dr. Drumbore may also recommend specific nutritional supplements. Nutritional supplements have been proven to be safe when taken as directed, yet there is always a chance for an adverse reaction from any product. If you feel you are having a reaction to a recommended nutritional supplement, stop using the product until you can discuss the matter with Dr. Drumbore.

Any unopened nutritional supplement may be returned within 30 days of initial purchase for a full refund. Opened products or expired products will not be accepted for return. Products sold at Center Street Chiropractic are sold at retail cost.

All medication changes need to be made by your medical physician (M.D.).

If you have any questions regarding this consent form, please talk with Dr. Drumbore.

I have read and understood the above nutritional consent form and I do not have any questions or concerns.

Patient signature

date

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY
PRACTICES FOR PROTECTED HEALTH INFORMATION**

I acknowledge that I have received Center Street Chiropractic, LLC's Notice of Privacy Practices for protected health information.

Date: _____

Name of Patient: _____
Print Name

Signature of Patient/Personal Representative