CONTINUUM INTEGRATED

Patient Consent for Treatment

I, ________________________________, hereby give my full consent for my child/teen,________________________________, or myself to receive services from *CONTINUUM INTEGRATED.* I will notify *CONTINUUM INTEGRATED* of any changes immediately as they occur or until it is determine that services are no longer necessary. If I am referring my child/teen for behavioral healthcare services, I certify that I have legal responsibility for this child/teen, and I am authorized to seek treatment for him/her.

I understand that *CONTINUUM INTEGRATED is* behavioral healthcare organization that is comprised of physicians, psychologist, social workers and counselors who work together as a team to provide behavioral healthcare. Professionals have separate appointments depending on the needs identified during individual and family sessions.

I understand that there is an expectation that I/we will benefit from the services provided, but there is no guarantee that this will occur. There is also no guarantee regarding the duration of treatment. I understand that my sessions may deal with disturbing and difficult topics may elicit uncomfortable emotions and may lead to individual decisions that may be temporarily disturbing for me and my family. I also understand that all information disclosed within my session is confidential and will not be revealed to anyone outside the supervising team without written permission unless required by law or necessary to comply with the requirements of accrediting agencies. Disclosure may be required by law: (1) when there is a reasonable suspicion of abuse/neglect to a child/teen, dependent or elder adult; (2) when the patient communicates a threat of bodily injury to self or others; or (3) when disclosure is required pursuant to a legal proceeding.

I understand that I have the right to refuse services and to discontinue services at anytime. Also *CONTINUUM INTEGRATED* may discontinue services for the following reasons: 1) the goal(s) of treatment has been successfully achieved, 2) two consecutive missed appointments without notification, 3) three missed appointments without notification within 60 days or 4) no contact with the therapist within 30 days after last appointment. I understand that I will be financially responsible for any court reports, appearances or consultations that are required in association with the treatment received.

AUTHORIZATION TO SIGN ON BEHALF OF A MINOR

Where the child/teen's biological parent is not married (separated, divorced, etc.) or custody is legally held by another person(s), a document showing authority to act on the child/teen's behalf is required by regulation to be filed in the patient's chart.

I, ____, confirm that I am (*please check one)*:
☐ The biological or adoptive parent having legal custody generally since birth, i.e., not separated or divorced (no need to provide legal documentation); or

The following must provide legal documentation:

☐ The managing conservator; or
☐ Other legal guardian and have been granted guardianship by the court or biological parents.
Please describe type: ____

Signature of Parent/Guardian: ____ **Date:** ____________________________
Signature of patient (16 yrs. and older): _______________________________________ _ **Date:** ____________________________
Witness: ____ **Date:** ____________________________

I acknowledge that I have read and/or received a copy of *CONTINUUM INTEGRATED's* "Notice of Privacy Practices."
☐ Yes (You are welcome to ask the receptionist for a paper copy to take with you.)
☐ No Please describe reason: ____

Coordination of Benefits

Patient's Name: ___________________________________ DOB____

Please fill out this form completely. Some insurance companies require this information in order to pay your claims

SECTION A- PRIMARY INSURANCE (Policyholder's Information)

Name of Insurance Company:________________________________ Name of Policyholder:__________________________

Effective Coverage Dates: Start: ___/___/___ End: ___/___/___ Insurance ID Number: __________________________

Address of Insurance Company:____

City: _______________________________________State: _____________________Zip: ____________________________

Phone Number of Insurance Company: ____

Policyholder's Employer:____

Do you have any other insurance coverage other than what has been provided to our staff?

____ No – Skip Section **B** below and sign form

____ Yes—**Answer questions below in Section B and sign form.**

SECTION B- SECONDARY INSURANCE

Is the other insurance coverage offered through the patient/parent's or caregiver employer? ___No ____Yes

Name of Insurance Company: ____

Address of Insurance Company: ____

City: _______________________________________State: _____________________Zip: ____________________________

Phone Number of Insurance Company: ____

Name of Policyholder: ____ Relationship of Policyholder to Patient:___________

Effective Coverage Dates: Start: ___/___/___ End: ___/___/___ Type of coverage: ___ Individual ___ Family

SECTION C – NON-INSURANCE

I, __________________________, agree to pay *CONTINUUM INTEGRATED* $ _______ each time services are rendered

***CONTINUUM INTEGRATED* has verified my insurance benefits as follow:** Deductible: ______________ Co-pay: __________ Other_________

I agree to pay this amount and ensure that my benefits are assigned to *CONTINUUM INTEGRATED.* I give permission to CONTINUUM INTEGRATED to bill my insurance directly. I understand that verification of coverage is not a guarantee of payment. If my insurance company does not pay benefits as verified, I understand that any remaining balance will become my responsibility. I understand that if I do not provide the required insurance documentation/proof of income to *CONTINUUM INTEGRATED,* no further appointments will be scheduled. I agree to inform *CONTINUUM INTEGRATED* of any changes in my insurance coverage in writing. I understand benefits will be reconfirmed by *CONTINUUM INTEGRATED* periodically. I recognize my payment may change if any new information is gained.

Patient, Parent/Guardian Signature: ____ Date: ___________________________

CONTINUUM ***Integrated***

3003 South Loop West Suite #475
Houston, Texas 77054-1381

Phone # 713-383-0888   Fax # 713-383-0895

NEW PATIENT INFORMATION

Hours – Outpatient appointments are available Monday through Friday 9:00 AM to 6:00 PM. Saturday appointments are available until 3:00 PM and by appointment only. Treatment Program such as Intensive Outpatient Programs, Partial Hospitalization Programs, and School Based Interventions have separate schedules which may be obtained from medical assistants.

Emergency Number -The office number (713) 383-0888 is answered 24 hours a day either by the office staff or by our answering service after hours or when the office is close for meetings.

Weather Warnings - In the event severe weather occurs, as reported by the major television networks, adjustments in patient schedules may occur automatically. We ask that patients/guardians call the 24 hour number to determine if the office has been closed.

Appeals and Grievances- I also acknowledge that I may submit a grievance to the provider or the administrator any time to register a complaint about any aspect of my care. If I am not satisfied with the response I receive, I may submit the grievance to my insurer, or the Joint Commission. Phone numbers are available through staff or the website.

Appointments/Cancellations - We require that you notify our office of cancellations no later than ***the business day before your appointment.*** Depending upon the presence of prior “Cancellations” and/or “No Shows” patients may be offered a work-in period of time until a consistent pattern compliance has been demonstrated. Please initial_____Date_______.

Missed Appointments and/or No Shows – When appointments are scheduled and patients fail to communicate about continuing treatment, a discharge from services (closing of an active chart) may occur within sixty days after the last “Missed or No Show” appointment. Patients may start treatment again, if it is deemed necessary by our office. Some patients may be referred to other treatment providers, when appropriate.

Proof of Coverage or Financial Eligibility – Proof of coverage must be provided prior to the first appointment. Patients who require monthly renewals of insurance coverage must provide proof of eligibility prior to the first appointment of a new month. In all instances, staff must establish the existence of coverage prior to an appointment with any treatment provider.

Payment - Co-payment is expected at the time of service to demonstrate commitment to improving your health. We accept many major medical insurers, and we will bill your insurance carrier for you, however, if your claim is denied, it becomes your full responsibility to pay for services. A credit card payment option is available upon request.

Patient or Responsible Party Agreement: I/we have:
1. Read and understand this New Patient Information.
2. Agree to the provisions stated herein.
3. Consent to the release of appropriate treatment information to the primary care physician referring doctor or, professional, insurance company or other third party paying for services.
4. Authorize payment of medical benefits directly to ***CONTINUUM*** **Integrated**.

_______________________________________   _____________________

Signature of Patient, Parent or Guardian   Date

CONTINUUM INTEGRATED HEALTH SERVICES
Specializing in Treatment of
Children, Adolescents, Adults, and Families

PATIENT CONSENT FOR DISCLOSURES

Primary Language: Patient- English Spanish
Parent- English Spanish

In General, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication made by alternative means, such as sending correspondence to individual's office instead of the home.

Home Telephone (   )______________________
Cell Number (   )______________________

____OK to leave message with detailed information
____Leave message with callback number only

Work Telephone (   )______________________

____Ok to leave message with detailed information
____Leave message with callback number only

Written Communication
___Ok to mail to my home address
___Ok to mail to my work/office address
___Ok to fax to this number (   )________________

E-mail address ________________________________
___Ok to send documents
___Ok to send message

____________________________________ ____________________
Patient/ Parent Signature Date

____________________________________ ____________________
Print Patient/Parent Name Patient Date of Birth

Authorized persons that can act on my behalf:

Print Name	Relationship	Contact Number
______________________	______________	( )______________
______________________	______________	( )______________

Patient's Name: ________________________ DOB: _______________ Date: ______________

Safety and Quality of Care Standards for New and Established Patients

We highly recommended that the number of visitors be limited when in this treatment environment. Signs are placed in the waiting room(s) to help us to respond to our quality of care and safety concerns. If we find it necessary, we will advise patients, parents or guardians of our concerns about the risk we observe in the environment. If the need occurs to respond to uncontrolled or high risk behaviors, staff will be professional and interested only in the well-being of our patients and visitors.

Examples of risks to safety and quality include:
Unaccompanied children (16 or younger) are prohibited from walking around or wandering around anywhere in this business building. Children and adults who leave the waiting room to sit outside our doors or anywhere on the 4th floor are considered a safety hazard by building management..

Risk of injury or destruction of property may occur when additional children are brought to the office. We ask that parent(s) bring only patients to the facility unless requested.

Risk of injury or destruction of property occurs when over-active or uncontrolled behaviors exists while waiting. Injury to any child or adult is unwanted and we believe that we are all responsible for maintaining a low risk and safe environment of care.

Inappropriate or Disruptive Waiting Room Behaviors
We do not tolerate threatening or aggressive behaviors in our waiting room from patients, parents, guardians, visitors or staff. Management staff will respond to statements unbecoming to a calm, orderly and pleasant environment. A discharge from treatment may be swiftly done and services will be terminated. If necessary we will contact police to have patients or visitors removed by the appropriate authorities.

Inappropriate Telephone Behavior
We do not tolerate inappropriate, demanding or threatening communication from patients, parents or guardians. Our telephones are usually very busy. When frustrations weigh heavily upon you concerning any issue(s), we strongly recommend that you talk privately with the assigned therapist during your next appointment. If repeated incidents of inappropriate telephone behaviors are reported, discharge from services may occur.

I have read and understand that repeated incidents of inappropriate or disruptive behaviors may lead to discharge from treatment.

____ _____________________________________

Parent Signature Date

CONTINUUM
SPECIALIST IN BEHAVIORAL HEALTH CARE

3003 South Loop West, Suite 475
Houston, TX 77054-1381

NOTICE OF PRIVACY PRACTICE AND ACKNOWLEDGEMENT

I understand that in accordance with the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up care among the multiple health care providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your NOTICE OF PRIVACY PRACTICE containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its NOTICE OF PRIVACY PRACTICE from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the NOTICE OF PRIVACY PRACTICE.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my request restriction, but if you do agree, then you are bound to abide by such restrictions.

Patient Name (print):______________________________ DOB:___________________________

SIGNATURE:_____________________________________ DATE:__________________________

Relationship
To Patient: Self Parent Legal Guardian Other______________________

If patient is minor:
Parent or Guardian ***PRINT NAME***:____

____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this notice of Privacy Practices Acknowledgement, but was unable to do so as document below:

Reason:____ Date:__________________ Initials:_______

OVERT AGGRESSION SCALE (OAS)
IDENTIFYING DATA

Name of Patient:___________________________ Date:_________________________________
Sex of Patient: 1 Male 2 Female Name of Rater: __________________________

☐ No aggressive incidents (verbal or physical) against self, others, or objects during the shift.

AGGRESSIVE BEHAVIOR (Check all that apply)

VERBAL AGGRESSION	PHYSICAL AGGRESSION AGAINST SELF
☐ Makes loud noises, shouts angrily ☐ Yells mild personal insults (e.g., "You're stupid!") ☐ Curses viciously, uses foul language in anger, makes moderate threats to others or self ☐ Makes clear threats of violence towards others of self (e.g., "I'm going to kill you") or requests to help to control self	☐ Picks or scratches skin, hits self, pulls hair (with no or minor injury only) ☐ Bangs head, hits fist into objects, throws self onto floor or into objects (hurts self without serious injury) ☐ Small cuts or bruises, minor burns ☐ Mutilates self, makes deep cuts, bites that bleed, internal injury, fracture, loss of consciousness, loss of teeth
PHYSICAL AGGRESSION AGAINST OBJECTS	**PHYSICAL AGGRESSION AGAINST OTHER PEOPLE**
☐ Slams door, scatters clothing, makes a mess ☐ Throws objects down, kicks furniture without breaking it, marks the wall ☐ Breaks objects, smashes window ☐ Sets fires, throws objects dangerously	☐ Makes threatening gesture, swings at people, grabs at clothes ☐ Strikes, kicks, pushes, pulls hair (without injury to them) ☐ Attacks others causing mild to moderate physical injury (bruises, sprains, welts) ☐ Attacks others causing severe physical injury (broken bones, deep lacerations, internal injury)

INTERVENTION (Check all that apply)

☐ None ☐ Talking to patient ☐ Closer observation ☐ Holding patient	☐ Immediate medication given by mouth ☐ Immediate medication given by injection ☐ Isolation without seclusion (time-out) ☐ Seclusion	☐ Use of restraints ☐ Injury requires immediate medical treatment for patient ☐ Injury requires immediate treatment for other person

COMMENTS:

MEDICATION HISTORY

First Name: Last Name: MI:	Today's Date:
Date of Birth:	List drug allergies:
Sex: (circle) M F	List food allergies:
Name of Primary Care Physician:	Physician's Phone Number:

WHAT MEDICAL CONDITIONS HAVE THE PATIENT HAD?

	High blood pressure		Emphysema		Bleeding Disorders		Hepatitis		HIV/AIDS
	Angina		Asthma		Cancer		Eating Disorder		Insomniac
	High Cholesterol		Bronchitis		Kidney Disease		Fevers		Migraines
	Heart Problems		Nasal allergies		Liver Disease		Tuberculosis		Thyroid Condition
	Obesity		Eczema		Crohn's Disease		Street Drug Use		Chronic Pain
	Diabetes		Ear Infection		GERD		Sleep Apnea		Brain Injury
	Lupus		Peptic Ulcer Disease		Seizures		Sickle Cell		Bed Wetting
	Head Lices		Ring Worm		Arthritis		STD		Priapism
	Other								

WHAT MEDICAL CONDITIONS RUN IN YOUR FAMILY?

Medical Condition	**Medications Prescribed**	**Hospitalizations**	**Relation to the Parent**
High Blood Pressure			
Stroke			
Heart Problems			
Obesity			
Diabetes			
High Cholesterol			
Cancer			
Depression			
Other			

WHAT OVER THE COUNTER MEDICINE ARE YOU TAKING?

	Ibuprofen (Motrin)		Cough medicine (Robitussin)		Coffee _______cups per day
	Acetaminophen (Tylenol)		Laxative (Exlax)		Cigarettes______ packs per day
	Antihistamine (Benadryl)		Antacids (Tums)		Alcohol_____drinks per day
	Multiple Vitamins (Centrum)		Antidiarrheals (Kaopectate)		
	Herbal Products		Other		Date of last period:_____________
	GERD		1.		Current method of contraception_____
	Nasal decongestant (Afrin)		2.		
	Oral decongestant (Sudafed)		3.		Pregnant? Yes No

Patient/guardian signature: ____________________ Relationship to patient:________________ Date:______________

Medication Tracking Chart

Patient Name:_________________________

Date:______________________________

Name of Medicine	Dose How much & how often	Purpose	Date started	Date Stopped	Type of Medicine*	Notes
Example: Compazine	(1) 10mg tablet /6hrs	Nausea	1/26/11	2/3/11	P	

***For Type of Medicine, use the following codes:**

P= Prescription **V**= Vitamin **O**= Other (please list)

OTC= Over the Counter **M**=Mineral

CONTINUUM INTEGRATED
MEDICAL REGISTRATION AND HISTORY

1. PATIENT INFORMATION

Date: ____

Patient Name: ____
Last Name First Name Initial

Address:____

City: ________________ State: ________ Zip: ___________

Home(_____)____

Cell Phone (_____) _________________________________

Work (_____)____

Primary Language:___________________________________

Sex: ☐ M ☐ F Age:_____ Date of Birth: _______________

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient's SSN: __________________________________

Occupation: ______________________________________

Patient's Employer/School:___________________________

Whom may we thank for referring you? _________________

PARENT/ GUARDIAN OR NEXT OF KIN:

Name:_______________________________________
Last Name First Name Initial

Phone: ____

Relationship: _____________________________________

IN CASE OF EMERGENCY CONTACT:

Name:____

Relationship: _____________________________________

Home (_____) ______________________________________

Cell Phone (_____) _________________________________

Work Phone (_____) ________________________________

2. INSURANCE INFORMATION

Who is responsible for this account? __________________

Relationship to Patient:____________________________

Date of Birth: _____________ SSN#: ________________

Insurance Company:_________________________________

Policy I.D.#: _____________________________________

Group #: ____

Is the patient covered by additional Insurance? ☐ Yes ☐ No

3.PRESENTING PROBLEM (This section must include the reason for the visit in your own words)

Presenting Problem: ________________________________

____

____

____

____

____

4. MEDICATIONS/ALLERGIES

List medications the patient is currently taking:___________

____

____

____

____

Pharmacy Name: ____________ Phone (____) ___________

List allergies to medication or substances: ______________

____

____

5. MEDICAL HISTORY (Check ✓ symptoms the patient currently has or have had in the past year) (All information is strictly confidential)

GENERAL
- ☐ Fatigue
- ☐ Coughing
- ☐ Dizziness/Fainting
- ☐ Chronic Fever
- ☐ Unexpected Weight Gain
- ☐ Headache
- ☐ Unexpected Weight Loss
- ☐ Loss of Sleep
- ☐ Wheezing
- ☐ Shortness of Breath

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Heartburn
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Stomach Pain
- ☐ Excessive Thirst
- ☐ Vomiting Blood
- ☐ Hemorrhoids
- ☐ Abdominal Pain
- ☐ Nausea
- ☐ Rectal Bleeding

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred Vision
- ☐ Sore Throat
- ☐ Difficulty Swallowing
- ☐ Double Vision
- ☐ Ear Discharge/Ache
- ☐ Hay Fever
- ☐ Hoarseness
- ☐ Loss of Hearing
- ☐ Nosebleeds
- ☐ Persistent Cough
- ☐ Ringing in Ears
- ☐ Sinus Problems

MEN ONLY
- ☐ Erection Difficulties
- ☐ Lump in Testicles
- ☐ Other

WOMEN ONLY
- ☐ Extreme Menstrual Pain
- ☐ Bleeding Between Periods
- ☐ Breast Lump
- ☐ Other

Date of Last Menstrual Period ____________________

Date of Last Pap Smear ____________________

Have you had a Mammogram ______________

Method of Contraception: ______________________________

MUSCULOSKELETAL

Pain, Weakness, aching or swollen
- ☐ Arms
- ☐ Hips
- ☐ Back
- ☐ Legs
- ☐ Feet
- ☐ Neck
- ☐ Joints
- ☐ Muscles

NEUROLOGICAL
- ☐ Numbness
- ☐ Paralysis

GENITO- URINARY
- ☐ Bed- Wetting
- ☐ Frequent Urination
- ☐ Painful Urination

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ High/Low Blood Pressure
- ☐ Irregular/Rapid Heart Beat
- ☐ Poor Circulation
- ☐ Swelling of Ankles
- ☐ Varicose Veins

SKIN
- ☐ Bruise Easily
- ☐ Hives
- ☐ Itching/Rash
- ☐ Change in Moles
- ☐ Scars
- ☐ Sore that will not heal

Check ✓ conditions the patient currently has or has had in the past

☐ AIDS	☐ Chicken Pox	☐ HIV Positive	☐ Polio
☐ Appendicitis	☐ Diabetes ☐ Type I ☐ Type II	☐ Kidney Disease	☐ Prostate Problem
☐ Arthritis	☐ Emphysema	☐ Liver Disease	☐ Rheumatic Fever
☐ Bleeding Disorders	☐ Epilepsy	☐ Measles	☐ Scarlet Fever
☐ Breast Lump	☐ Glaucoma	☐ Migraine Headaches	☐ Stroke
☐ Cancer	☐ Heart Disease	☐ Multiple Sclerosis	☐ Thyroid Problems
☐ Cataracts	☐ Hepatitis	☐ Mumps	☐ Tuberculosis
☐ Asthma	☐ Herpes	☐ Pacemaker	☐ Ulcers
☐ Chemical Dependency	☐ High Cholesterol	☐ Pneumonia	☐ Venereal Disease
☐ Depression	☐ Edema	☐ Mood Swings	☐ Anxiety
☐ AD/HD	☐ Bipolar Disorder	☐ Stress Disorder	☐ Iron Deficiency
☐ Sickle Cell Anemia	☐ Irrational Beliefs	☐ Other: ____________________	

☐ Suicide Attempt (s) (When____

☐ Hospitalization (s) (When/Reason ____

____

Is the patient currently seeing a physician for any of the above problems? ☐ Yes ☐ No:______________________________

Are any of the above health concerns currently not adequately being addressed by a physician? ☐ Yes ☐ No ______________

______________________________________ Date of your last physical exam or doctor's appointment: __________________________

In the last 6 months has the patient had any significant medical treatment or procedures? ☐ Yes ☐ No: ____________________

____

Has the patient ever had a minor or major brain injury (concussion, blackout(s)? ☐ Yes ☐ No ________________________

Does the patient smoke? If Yes, how much? _________ does the patient drink alcohol? If Yes, how much and how often _______

____

Has the patient signed an advanced directive, such as a living will or durable power of attorney for health care? ☐ Yes ☐ No

If Yes, where is it located? ____

6. SOCIAL ENVIRONMENT

Person Completing Form:_________________________________Relation: Self or Parent/Guardian:_____________________
Primary Care Doctor/Pediatrician:____
Other Doctor(s) treating You or Your Child:____
If child, have all required immunizations for his/her age group been completed?______________________________

(1)The Family--- list yourself and all members living in the home including your child:

Name	Sex	Age	Place of Work or School

(2)If there have been any separations or divorces, give date(s),name(s) of other involved figures. If a child, list which parent(s) have legal and which have physical custody: ____

(3)Family members not living with you (for example, grown children, boyfriend, parents):_______________________

(4)If the patient is a child, at what age did the patient:
Walk_____Say Single Word_____Fully Toilet Trained_____Ride a Bike_____ Write His/Her Name_____ Read 20-30 Words_____

(5)If the patient is a child, were there any difficulties with the birth, infancy, or preschool development:________________

(6)Are there any family members (parents, siblings, grandparents, aunt, uncles or cousins) who have emotional and mental health, or substance abuse difficulties (include behavior, school or work problems, seizures/epilepsy)?______________________

(7)Have you or anyone in your family ever seen a counselor or doctor for emotional, mental health or substance abuse difficulties? If Yes, who and when: ____

(8)Have you or anyone in your family ever taken any medications for emotional, mental health or substance abuse difficulties? If Yes, who and when: ____

(9)Have you or anyone in your family ever been in a hospital for emotional, mental health, or substance abuse difficulties? If Yes, who and when:____

(10)Have you or anyone in your family ever attempted suicide?______________________________________

(11)How do you or the patient get along with others in the family?___________________________________

(12)How do you or your child do in his/her school/work?____

(13)If the patient is a child, has special education classes been recommended? If yes, when and for what reason? ____________

(14)What other things would be helpful to know about you, your child or your family? ___________________________

7. SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I have a change in health, address, or insurance coverage.

Signature of Patient, Parent, or Guardian	Date
Please Print Name of Patient, Parent, or Guardian	Relationship to Patient
Reviewed for Completion by	Date