**New Patient Welcome Packet**

Dear Patient,

Thank you for choosing Gladstone Primary Care, we look forward to providing you with exceptional care. Enclosed you will find our New Patient Forms. Please fill these forms out completely prior to your appointment and return them by fax, mail, or in person.

At your first visit, please bring:

* Completed New Patient Forms (if you have not already submitted them)
* Your photo ID
* Your insurance card(s)
* The bottles of all your medications, both prescription and over-the-counter meds (not just a list – please bring the actual bottles)
* If the patient is a minor, bring a vaccination record
* You will be responsible for your co-pay at arrival

We ask that all new patients arrive at least 15 minutes early so that we can confirm your medical history information.

If you are unable to keep your appointment or need to reschedule for any reason, we ask for a minimum of 24-hour notice.

Sincerely,

Gladstone Primary Care

**Practice Policies**

**Office Hours: Monday - Thursday 7:00am - 5:00pm, Friday 8:00am - 12:00noon**

**Appointments**: We ask that you arrive on time for your appointment. Please call 256-773-6017 to notify us if you are not able to be on time or if you need to reschedule or cancel. After office hours our answering service will assist you and forward your message to us the next business day.

**Prescriptions**: It is important to have accurate documentation of your medications, therefore please bring all prescription bottles to each appointment. If you require a prescription outside of an appointment, please call during office hours. We require 24-hours for prescriptions to be ready for pick-up or sent to your pharmacy. Prescriptions may only be picked up by the patient or person listed on the Disclosure Release.

**Forms**: We are happy to complete health forms during your appointment at no charge, if time permits. Please complete all sections designated as “patient, employee, or beneficiary”. Long forms may require more time and can be picked up when ready. Requests outside an office visit will be subject to a processing fee as listed:

* All other requests for medical records will be charged at the currently existing rate as follows:
* $5.00 Administrative Fee, $0.50 cents per page, Postage fees if applicable.
* Any documentation that needs to be completed with medical information and requires a physician signature including FMLA and insurance requests will be charged a processing fee of $25.00.

**Pain Control:** Helping tocontrol pain and making you comfortable is important to us and we can provide pain relief for a short time if required. However, we do not specialize in chronic pain management, and we will refer you to a provider who does if you require long-term pain management. The decision to provide controlled substances is at the sole discretion of the provider.

**Dismissal**: We sincerely hope we never have to part ways with a patient, but occasionally extreme circumstances may make this necessary. If this occurs, you will be notified by certified mail and will have 30 days from that point to find another physician. During those 30 days we will be able to offer only urgent care.

**Financial Policy**

**Proof of Insurance**: Please bring your current government issued identification and insurance card to each appointment. Delays in verification of insurance may result in you being responsible for fees.

**Insurance**: Please be aware that knowing your insurance coverage is your responsibility including knowing which facilities and providers are covered. Please contact your insurance company for questions about your coverage.

**Out of Pocket Fees**: We collect co-payments at the time of service. You will be responsible for non-covered or routine charges, deductibles, and/or co-insurance amounts that apply.

**Non-covered services**: On occasion a service may not be covered by your insurance. We will notify you prior to the service if we are aware and payment or a portion will be due at the time of service.

**Returned Checks**: There is a $30 charge for returned checks.

**Lindsay Smith, MD • Juliana Clark, CRNP**

**PATIENT INFORMATION**

***Legal Name as it appears on your Government-Issued ID***

**Last Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last First Middle Initial

**Maiden/Other Last Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Social Security #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Zip:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cell Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Home Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**May we contact you on your cell?** □ Yes □ No **May we leave a message on your voicemail?** □Yes □No

**Sex:** □ M □ F □ Prefer Not to Say **Marital Status:** □ Divorced □ Life Partner □ Married □ Single □ Widow

**Race:** □ African American □ American Indian □ Asian □ Caucasian □ Hispanic □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employment Status:** □Full-Time □Part-Time □Retired □Not Employed □Active Military □Disabled □Housewife □Self-Employed

**Employer:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Employer Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employer Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Zip:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Insurance to File**

|  |  |
| --- | --- |
| Insurance Company: | Insured’s Name: |
| Policy Number: | Insured’s Date of Birth: |
| Group Number: | Relationship to Patient: |
| Insured’s Social Security Number: | |

**Secondary Insurance to File**

|  |  |
| --- | --- |
| Insurance Company: | Insured’s Name: |
| Policy Number: | Insured’s Date of Birth: |
| Group Number: | Relationship to Patient: |
| Insured’s Social Security Number: | |

**Person Responsible for Account:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I agree that payment will be made at the time of service. I agree to pay all co‐pays, non‐covered or routine charges, deductibles and co‐insurance amounts that apply. In the event this account is turned over to a collection agency for collection, I will be responsible for all collection fees, court costs and attorney’s fees. I authorize Gladstone Primary Care to release information to insurance carriers and for insurance carriers to release information to Gladstone Primary Care concerning my illness, treatment and payments (including workmen’s compensation) and I hereby assign to the physicians all payments for medical services rendered to myself or my dependents if assignment applies.

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

**Medical History Information**

What **CURRENT** symptoms are you experiencing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Have you seen another healthcare provider in the past 24 months?

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Medical History:** Check all that apply in your **Medical HISTORY**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Allergies |  | Chronic Renal Disease |  | Gout |  | Prostate Issues |
|  | Abnormal Pap Smear |  | Cirrhosis |  | Head Injury |  | PUD - Stomach Ulcers |
|  | ADD / ADHD |  | Congestive Heart Failure |  | Heart Attack |  | PAD-Peripheral Artery Disease |
|  | Anemia |  | Constipation |  | Heart Disease |  | Rash / Psoriasis |
|  | Anxiety |  | COPD |  | Hepatitis A / B / C (Circle One) |  | Rheumatoid Arthritis |
|  | Arthritis |  | Crohn’s Disease |  | High Cholesterol |  | Seizure Disorder |
|  | Asthma |  | CVA / Stroke |  | High Blood Pressure |  | Sexually Transmitted Disease |
|  | Atrial Fibrillation / Palpitations |  | Dental Issues/Dentures |  | HIV/AIDS |  | Shortness of Breath |
|  | Back Pain |  | Depression |  | Irregular Periods |  | Sleep Apnea / Insomnia |
|  | Bi-Polar Disorder |  | Diabetes |  | Joint Pain |  | Use of CPAP |
|  | Blood in Urine |  | Diarrhea |  | Kidney Disease |  | Thyroid Disorder |
|  | Blood Transfusion |  | Diverticulitis |  | Liver Disease |  | Trouble Swallowing |
|  | Bloody/Black Stools |  | Dizziness / Vertigo |  | Lupus |  | Tuberculosis |
|  | Blurry Vision/Eye Problems |  | DVT (Blood Clots in Legs) |  | Memory Loss |  | Urinary Pain / Deficiency |
|  | Chest Pain |  | Extremity Swelling |  | Neurological Disorder |  | UTI – Recurrent |
|  | Chronic Cough |  | GERD (Acid Reflux) |  | Osteoarthritis |  | Vascular Disease |
|  | Chronic Headaches/Migraines |  | GI Bleed |  | Pelvic Pain |  | Weight Loss/Gain |

Cancer (Type): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Surgical History:** Check all that apply and/or use blank to list surgical procedures not listed

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Appendectomy |  | CABG (Heart Bypass) |  | Gastric Bypass |  | Prostate Surgery | |
|  | AV Fistula Creation |  | Cardiac Surgery |  | Hemorrhoidectomy |  | Thyroid | |
|  | AV Graft |  | Carotid Endarterectomy |  | Hysterectomy Full / Partial |  | Tonsils / Adenoids | |
|  | Back Surgery |  | Colon Resection/Surgery |  | Nephrectomy |  | Heart Valve Replacement | |
|  | Bronchoscopy (Lung Scope) |  | Gallbladder Removed |  | Pneumonectomy |  | Vascular Surgery | |
|  | Amputation: Type/Location: | | | | | | |
|  | Implant: Type/Location: | | | | | | |
|  | Joint Replacement: Type/Location: | | | | | | |
|  | Transplant: Type/Location: | | | | | | |

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Last Screening:** Colonoscopy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eye Exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Eye Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Skin Screening: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dermatologist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Males: PSA Screening: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Females: Last PAP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Menstrual Period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mammogram: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Bone Density: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Method of Contraception: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History:** Check all that apply and/or use blank to list other medical history not listed

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Father | Mother | Father's Parents | Mother's Parents | Other Relationship (Specify) |
| High Blood Pressure |  |  |  |  |  |
| Heart / Artery Disease |  |  |  |  |  |
| Heart Attack |  |  |  |  |  |
| Diabetes |  |  |  |  |  |
| Stroke |  |  |  |  |  |
| Arthritis |  |  |  |  |  |
| Thyroid Disorder |  |  |  |  |  |
| Asthma |  |  |  |  |  |
| Cancer (Type) |  |  |  |  |  |
| Other (Specify) |  |  |  |  |  |

**Social History:**

Smoke Cigarettes: No \_\_\_\_\_ Yes \_\_\_\_\_ Former Smoker: \_\_\_\_\_ If yes, how many per day? \_\_\_\_\_\_\_\_\_\_

If former, how long ago did you quit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Vape: No \_\_\_\_\_ Yes \_\_\_\_\_

Smokeless Tobacco: No \_\_\_\_\_ Yes \_\_\_\_\_ Exposed to secondhand smoke: No \_\_\_\_\_ Yes \_\_\_\_\_

Drink Alcohol: No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, how much per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Illegal Drugs: No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, what, and how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications and Allergies**

**Your PREFERRED Pharmacy (Name & Location): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medications:** List all current medications including over the counter (Please also bring bottles to each appointment)

|  |  |  |
| --- | --- | --- |
| Medication | Dosage/Strength (MLs or MGs) | Frequency per Day |
|  |  |  |
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**List all Allergies including environmental and medication:**

|  |  |
| --- | --- |
| Allergic to: | Type of Reaction: |
|  |  |
|  |  |
|  |  |
|  |  |

**Date of Last Vaccine:** Flu: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Covid: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pneumonia: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Shingles: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tetanus: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Prevnar 13: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent Form**

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

***I authorize the release of my health information necessary to my treatment, continuity of care, and the processing of insurance claims to the following entities:***

Individual Insurance Companies Billing Services Providers Associated with Care

Hospital Lab and Ancillary Departments Agencies Associated with Care/EMR

**By signing below, you are signifying that you understand and agree to the release of your health information to the above listed entities for the purposes outlined.**

Patient/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any person(s) who we may speak to regarding your health information or that we may obtain your health information from, including family members, relatives, significant others:

|  |  |  |
| --- | --- | --- |
| **Name** | **Relationship** | **Phone Number** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Insurance release/assignment of benefit/payment authorization:**

Your fee for service is due and payable by cash, check, credit card, or debit card at the time of treatment. We may not participate in all insurance plans and if your plan is one in which we do not participate, please ask for an office receipt so you can file for reimbursement if applicable. Regardless of any insurance, the guarantor listed on the Patient Information Form is responsible for his/her bill. The guarantor will also be responsible for all charges incurred by collection agencies or past due accounts.

**By signing below, you are signifying that you understand and agree to the office and financial policies and the information regarding financial responsibility contained in the Patient Packet. You are agreeing to the release of your health information to the person(s) listed on this form. This listed of designated people can be updated at any time.**

Patient/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_