Capital Area Internal Medicine, Inc.

Sree L. Gogineni, M.D.

Ph: (703) 255-6010 Fax: (703) 255-6011

124 Park Street S.E., Suite 203
Vienna, VA 22180

44121 Harry Byrd Hwy #250
Ashburn, VA 20147
www.CapitalIMA.com

Patient Registration Form:

Personal Information

Social Security #: _____ Date of Birth:__/__/____ Age:____ Sex:☐M ☐F Marital Status:☐ M ☐ S ☐W ☐D

Patient's Name: Last _____ First _____ Mi_____

Patient's Address: _____ Apt#:_____

City: _____ State: _____ ZIP:_____

Home Telephone:_____ Work Telephone:_____Ext_____ Cell:_____

Employer: _____ Occupation _____

Employment Address _____ City: _____State: _____ ZIP: _____

Emergency Contact _____ Tel _____Relationship _____

Patients under the Age of 18

Parent or Guardian Name: Last_____First_____ Mi_____

Home Telephone:_____ Work Telephone:_____Ext_____ Cell:_____

Insurance Information

Plan Name: Effective Date:____/____/____ Primary Secondary

ID # _____Group # _____ Plan Telephone _____

Address_____ City _____ State _____ Zip_____

Policy Holder's Name_____ D.O.B____/____/____ SS#:____-____-

Policy Holder's Employer_____ Relationship to Patient_____

Plan Name: Effective Date:____/____/____ Primary Secondary

ID # _____Group # _____ Plan Telephone _____

Address_____ City _____ State _____ Zip_____

Policy Holder's Name_____ D.O.B____/____/____ SS#:____-____-

Policy Holder's Employer_____ Relationship to Patient_____

Source of Referral

Whom Can We Thank For the Referral (Name)

- Physician: _____
- Insurance Company: _____
- Family/Friend: _____
- Phone Book: _____
- Internet: _____
- Other: _____

Workman's Comp/Auto Accident

Is this visit a Workman's Compensation case? ☐ Yes ☐ No

If Yes -

Date of accident_____ W/C Ins. Company_____

Where:_____ When _____

Did you file claim? ☐ Yes ☐ No Claim #_____

Is this visit due to an Auto Accident? ☐ Yes ☐ No

If Yes -

Date of accident_____ Auto Insurance_____

Where:_____ When _____

Did you file claim? ☐ Yes ☐ No Claim # _____

Other Information

Do you have an Advance Medical Directive? ☐ Yes ☐ No

If yes, please provide a copy for your record; If No, please ask for information.

May we contact you to confirm your appointment? ☐ Yes ☐ No

If yes, please indicate preferred Means of Contact and circle 1-2-3 in order of priority

Telephone. # _____ Email Address: _____ Text: _____

Is it okay to leave a Message on your voice mail reminding you of your appointment? ☐ Yes ☐ No

Assignment of Benefits and Authorization to Release Medical Information

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to: Capital Area Internal Medicine Inc. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance within 45 days. Should it become necessary to turn my account over to an outside collection agency I will be responsible for collection cost, attorney fees, litigation fees and court costs. I hereby authorize Capital Area Internal Medicine, Inc. and its employees and agents, to release all information, reports and records if necessary to secure the payment of my account, including a discussion of my medical condition, to the insurance provider, rehabilitation provider, employer, hospitals, and doctors.

_____ _____ _____

Signature Patient/ Policy Holder Date

Responsible Person if Patient is a Minor: _____

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Privacy Practices and Consent

Patient Consent for Use and Disclosure of Protected Health Information

Please review this notice carefully. It describes how health information about you, as our patient, may be used and disclosed.

A. **Our commitment to your privacy** – We are committed to maintaining your privacy. We will create records of your health information and the treatment and services we provide to you. We are required by law to maintain your privacy and to notify you of our legal duties and privacy policies. We Reserve the right to revise or amend this Notice of Privacy Practices - the revised or amended notice will apply to all records created in the past or future. We will post a copy of our current notice in a visible location and you may request a copy of our current notice at any time.

B. We may use and disclose your individually identifiable health information (IIHI) in the following ways:

a) Treatment: We may use and disclose your IIHI to treat you, by having laboratory or radiology tests done to make a diagnosis or to order medication for you. People who work for our practice may use your IIHI to assist in your treatment.

b) Payment: We may use and disclose your IIHI in order to bill and collect payment for our service to you. We may contact your insurance company to check benefits pre-certify a treatment. We may use and disclose your IIHI to bill you or family members for your services.

c) Health care operations: We may use and disclose your IIHI to evaluate our quality of care or our business operation.

d) Appointment Reminders: We may use and disclose your IIHI to remind you of appointments.

e) Release of information to family/friends: We may release your IIHI to family or friends who are involved in your care (with your permission).

f) Disclosures Required by Law: We will use and disclose your IIHI when we are required to do so by federal, state or local law.

C. **Use and Disclosure of your IIHI in Special Circumstances**

a. Public Health: We may disclose your IIHI to public health authorities for:

i) Vital record- birth and death

ii) Reporting child abuse or domestic abuse (with the victims permission)

iii) Preventing or controlling disease or injury (including communicable disease)

b) Health Oversight Activities: These include investigations, inspections, audits, surveys: civil, administrative and criminal procedures and actions: other activities needed for compliance with government programs, civil rights law etc.

c) Lawsuits and Similar Proceedings: We may use and disclose your IIHI as requested by a court administrative or other lawful order. We will make an effort to inform you of the request.

d) Law Enforcement: We may release your IIHI if asked by a law enforcement official

i) To Investigate a crime

ii) In response to a warrant, summons, court order, subpoena etc.

e) Serious Threats to Health or Safety: of an individual or the public.

f) Military: We may disclose your IIHI if required by the appropriate authorities.

g) National Security: We may disclose your IIHI to federal officials authorized by law.

h) Workers Compensations: We may release your IIHI for these programs.

D) Your Rights Regarding your IIHI

a) **Confidential Communications:** You have the right to request that we communicate with you about your health in a particular manner. Please make a written request to our privacy officer. We will accommodate reasonable requests.

b) **Requesting Restrictions:** You have the right to request restrictions in our use or disclosure of your IIHI for treatment, payment or health care operations. Or to limit the individuals who get your information. We are not required to agree

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Patient Consent for Use and Disclosure of Protected Health Information (Cont'd)

b) **Requesting Restrictions:** You have the right to request restrictions in our use or disclosure of your IIHI for treatment, payment or health care operations. Or to limit the individuals who get your information. We are not required to agree to your request. Please make your request in writing to your privacy officer, including:
i) The information you wish restricted
ii) Whether you are requesting to limit our practice's use and/or disclosure.
iii) To whom you want the limits to apply.

c) **Inspection and copies:** You have the right to inspect and obtain a copy of the IIHI about you, not including psychotherapy notes. Please send a written request to your privacy officer. We may charge a fee for your costs. If we deny your request you may request a review of our denial (by another licensed health care, you may request a review of your denial (by another licensed health care professional).

d) **Amendment:** You may ask us to amend your IIHI if you believe it is incorrect or incomplete. Make the request in writing to our privacy officer. We may deny your request if we believe our information is accurate and complete or if the information is not part of the IIHI we keep.

e) **Accounting of Disclosure:** You have the right to request a list of certain non-routine disclosures our practice has made or your IIHI for non-treatment or operations purposes. Make your request in writing to our privacy officer, stating a time period(less than six year and after April 14, 2003). One list per year is free. We may charge for extra lists requested within a 12 month period.

f) **Right to a Paper Copy of this Notice:** Please contact the privacy officer.

g) **Right to File a Complaint:** If you believe your privacy rights have been violated, you may file a complaint with your privacy officer or with the Secretary of the Department of Health and Human Services. You will not be penalized for making a complaint.

h) **Right to provide authorization for other uses and Disclosures:** We will get your written authorizations for uses and disclosures that are not identified by this notice or permitted by law. Your authorization may be revoked at any time in writing.

I hereby give my consent for Capital Area Internal Medicine to use and disclose my IIHI as outlined above to carry out treatment, payment, and for health care operations (HCO).

With this consent, Capital Area Internal Medicine, may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the proactive in carrying out HCO, such as appointment reminders, insurance items and any calls pertaining to my clinical care.

With this consent, Capital Area Internal Medicine may mail to my home or other alternative location any items that assist the practice in carrying out HCO, such as appointment reminders and patient statements. I have the right to request that Capital Area Internal Medicine restrict how it uses or disclose to carry out HCO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Capital Area Internal Medicine to use and disclose my IIHI to carry out HCO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Capital Area Internal Medicine may decline to provide treatment to me.

Signed by: _____ Date_____
Signature of Patient or Legal Guardian

_____
Print Patient's Name

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Office Policy Information Sheet

PLEASE NOTE: All charges and/or fees are due at the time of service, when applicable. Please present your insurance card(s) and driver's license to the office staff with this completed form. We will copy them for your records and return them to you immediately.

Appointments: In scheduling appointments, it is our intent to see you as soon as possible, given the constraints of our mutual schedules. Our staff will offer you the first available appointment, and will ask you some basic questions. Our staff will make every effort to accommodate requests. We will make every effort to see you on time at your scheduled visit, however, to avoid delaying other patients; individuals arriving early for their appointments may not be taken until the scheduled time. Please be aware that emergencies do arise which might delay your scheduled appointment. You will receive a call reminding you of your appointment time. Please call us back if you need to change the time of your appointment to avoid any missed appointment charges

Prescription Refills: All prescription refills will be processed within 24 hours. Requests for refills for regularly prescribed medications made outside of scheduled office visits are subject to an additional service fee of $15 which will not be billed to your insurance. To obtain a prescription refill, we ask that you call our prescription line and leave a detailed message with all the information requested on the recording. Once the provider has authorized the refill, it will be forwarded to your pharmacy. If your provider has not seen you within the last six months, no prescription refills will be issued. If you are prescribed a medication requiring more frequent office visits you must be up to date with your visits to receive a prescription refill. It will be necessary for you to schedule an office visit in order for your prescription to be renewed. Patients are instructed to schedule their doctor visits before running out of medicine and have all needed prescriptions before leaving the office at the time of their appointments.

Clinical Phone Calls: To avoid disrupting daily patient flow, please choose the phone option and follow the instructions for a return call from a nurse. Please indicate where you may be reached during the day or whether we have permission to leave a message at the number provided. Messages are retrieved throughout the business day. Urgent requests are handled as soon as possible. All other calls requiring follow up will be returned before the end of the next business day.

Test Results: Results are generally received in our office within 7-10 days after tests have been performed. Our providers review all reports and you will be notified of the results.

Referrals: For those plans requiring referrals to specialty physicians, you must first receive authorization from your provider who is your designated primary care provider (PCP). To request a referral, please call the office at (703) 255-6010. If you have not been seen by your treating provider within the past six (6) months for the condition necessitating the referral, you will need to schedule an office visit prior to receiving the referral

Medical Records: Original records are the property of the Practice and will not be released. Per federal regulations, we require a signed Release of Medical Records form prior to processing of requests. Medical records will not be faxed. Pursuant to Virginia Code subsection B of 8.01-413, there will be charges surrounding duplication of records in the amount of $0.50 per page for up to 50 pages and $0.25 per page thereafter, plus all postage/shipping costs, and an administrative fee of $10.00. We require payment in advance. Processing will be completed within 15 days from the date we receive your signed authorization and payment. Urgent requests will be treated as such.

Financial Policies: To ensure care is available to all patients seeking our services, we require you to pay the patient portion of your payment in full at the time of visit. Payments may be made in the forms of cash, check, MasterCard/Visa. Please be aware that current federal regulations require us to collect all co-pays and bill for all services. To assist you in understanding your financial responsibilities, please refer to the Patient Financial Policy.

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Office Policy Information Sheet (Page 2)

Billing Inquiries - Please call (703) 831-4222 for all billing questions. Our staff makes every attempt to assist you at the time of your call. To facilitate their efforts, please have the necessary information available that you wish to discuss

MEDICARE AUTHORIZATION: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Capital Area Internal Medicine for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. If "other health insurance: is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

YOUR INSURANCE: We will be happy to bill your insurance carrier for you. Please note that we **do not take assignment on auto-related claims** or insurance carriers that we do not participate in. If your insurance requires a referral, it is **required** that **you have your referral with you at the time of service. It is your responsibility to ensure that your referral is current**. Co-payments/co-insurance is due at the time of service. In the event your health plan determines a service to be "not covered" or it has been over sixty (45) days with no payment from your insurance; then you will be responsible for the complete charge. In that event, we will bill you, and **payment is due upon receipt of that statement.**

I agree and understand that any funds I receive from my insurance company in connection with medical services and care rendered by Provider will be immediately signed over and sent directly to Provider. This is a direct assignment of my rights and benefits under my medical policy/plan. This payment will not exceed my indebtedness to Provider, and I agree to pay, in a timely manner, any balance of professional service charges over and above the payments made to Provider pursuant to this assignment of benefits.

Minor Patients: For all services rendered to minor patients, the adult accompanying the patient is responsible for payment

Cancelation: We require a twenty-four (24) hour notice for all cancellations; otherwise, there will be a $25 charge.

RETURNED CHECKS: It is our office policy to charge a fee of **$35.00 for any returned checks.**

COMPLETION OF FORMS: We will be happy to complete attending physician's statement, insurance and disability forms for our patients. The patient is responsible for payment of any fee prior to completion of the forms**. Please allow 10-14 business days for completion of forms.**

DELINQENT ACCOUNTS: We reserve the right to add reasonable interest and collection charges to any account over 45 days past due. Interest of 1.5% would be added on (for each month) if the bill is not paid within 45 days.

DECLARATION: I have read and I understand the financial and Office policy of the practice, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

_____ _____
SIGNATURE & NAME of patient / insured / guarantor / responsible party DATE

_____ _____
SIGNATURE & NAME of Co-Responsible Party DATE

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Health History Questionnaire

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	**Date of last physical exam:**
Race:	**Ethnicity:**

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio ☐ Other _____

Immunizations and dates:

☐ Tetanus
☐ Hepatitis
☐ Influenza
☐ Pneumonia
☐ Chickenpox
☐ MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed, when and if Resolved

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion? ☐ Yes ☐ No

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Health History Questionnaire

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Mild/Moderate/Severe	Type of Reaction

Non-Drug Allergies

Name the Drug	Mild/Moderate/Severe	Type of Reaction

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

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Health History Questionnaire

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)			
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)			
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)			
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)			
Diet	Are you dieting?	☐ Yes	☐ No	
	If yes, are you on a physician prescribed medical diet?	☐ Yes	☐ No	
	# of meals you eat in an average day?			
	Rank salt intake	☐ Hi	☐ Med	☐ Low
	Rank fat intake	☐ Hi	☐ Med	☐ Low
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola
	# of cups/cans per day?			
Alcohol	Do you drink alcohol?	☐ Yes	☐ No	
	If yes, what kind?			
	How many drinks per week?			
	Are you concerned about the amount you drink?	☐ Yes	☐ No	
	Have you considered stopping?	☐ Yes	☐ No	
	Have you ever experienced blackouts?	☐ Yes	☐ No	
	Are you prone to “binge” drinking?	☐ Yes	☐ No	
	Do you drive after drinking?	☐ Yes	☐ No	
Drugs	Do you currently use recreational or street drugs?	☐ Yes	☐ Np	
	Have you ever given yourself street drugs with a needle?	☐ Yes	☐ Np	
Other	Do You Take Birth Control Pills ? ☐ Yes ☐ No		Do You Take Tranquilizers? ☐ Yes ☐ No	
	Do You Take Stimulants/Pep Pills? ☐ Yes ☐ No		Do You Take Vitamins? ☐ Yes ☐ No	
	Do You Take Laxatives? ☐ Yes ☐ Io		Do You Take Sedativees/Sleeping Pills? ☐ Yes ☐ No	
Smoking Status (Please Circle)	Current Smoker		Former Smoker	Never smoked
	If Current or Former Smoker, Please answer the following Questions:			
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day
	☐ # of years	☐ Or year quit		

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WOMEN ONLY		
Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam?		

MEN ONLY		
Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?	☐ Yes	☐ No

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Health History Questionnaire

PAST MEDICAL HISTORY

Have You EVER had the following? Give AGE when first discovered; leave blank if no :

_____Diphtheria
_____Chicken Pox
_____Measles
_____German Measles
_____Mumps
_____Mononucleosis
_____Polio
_____Bronchitis
_____Emphysema
_____Asthma
_____Hay fever
_____Rheumatic fever
_____Rheumatic heart disease
_____Angina pectoris
_____Heart attack
_____Heart failure
_____Heart murmur
_____Hiatus Hernia
_____Ulcer
_____Diverticulosis
_____Diverticulitis
_____Hemorrhoids
_____Parasites (worms)
_____Hernia
_____L iver disease
_____Cirrhosis
_____Hepatitis
_____Yellow jaundice
_____Pancreatitis
_____Gallbladder trouble
_____Diabetes
_____High blood pressure
_____Thyroid disease
_____Kidney disease
_____Bladder trouble
_____Prostate trouble
_____Scarlet fever
_____Arthritis, Gout
_____Bursitis
_____Epilepsy, seizures
_____Migraine headaches
_____Nervous breakdown
_____Syphilis or gonorrhea
_____Glaucoma
_____Tuberculosis
_____Histoplasmosis, Sarcoidosis
_____Herpes
_____Anemia
_____Broken bones (which?) _____
_____Cancer (type?) _____
_____Stroke

Any other problems? _____
_____

Answer "yes" o r " no ":

Are you allergic to:
Penicillin _____
Sulfa _____
Mycins _____
Morphine _____
Codeine _____
Other drugs _____
_____

When was your last:
Complete physical _____
Eye exam for
Colonoscopy _____
Dental appt. _____
Tetanus shot _____
Pneumonia vaccine _____
Flu shot _____
Chest x-ray _____
EKG _____
Sigmoidoscopy _____
PSA _____

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Health History Questionnaire

FAMILY HEALTH HISTORY

GIVE NAMES OF ALL RELATIVES REQUESTED, NOTE ILLNESS OF THOSE LIVING OR DEAD. MARK AN "X" IF YES, LEAVE BLANK FOR NO.

NAME	If Living: AGE	CANCER	TUBERCULOSIS	DIABETES	ULCER	HEART ATTACK	HEART TROUBLE	STROKE	HIGH BLOOD PRESSURE	KIDNEY DISEASE	LIVER DISEASE	ALCOHOLISM	EPILEPSY	NERVOUS BREAKDOWN	ASTHMA	HAYFEVER	ALLERGIES	ANEMIA	BLOOD DISEASE	GLAUCOMA	MIGRAINE HEADACHES	GOUT	ARTHRITIS	If dead: AGE AT DEATH	CAUSE OF DEATH
FATHER:																									
MOTHER:																									
BROTHERS:																									
SISTERS:																									
SPOUSE:																									
CHILDREN:																									

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ADDENDUM

Patient Registration Information

Last Name: _____ M.I _____ Sex : ☐ Female ☐ Male

First Name: _____ Date of Birth:__/__/_____

Patient's Address: _____ Apt#:_____ City: _____

State: _____ ZIP:_____ Home Telephone:_____

Work Telephone:_____Ext_____ Cell:_____

PATIENT RECORD OF DISCLOSURES

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

I Wish to be contacted in the following manner (check all that applies):

☐ EMAIL PATIENT PORTAL _____
☐ O.K. TO SEND EMAIL PORTAL

☐ Home Telephone
- ☐ O.K. to leave message with detailed Information
- ☐ Leave message with call-back number only

☐ Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address

☐ Cell Phone
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Work Telephone
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

_____ _____
PATIENT SIGNATURE DATE

_____ _____
PRINT NAME DATE OF BIRTH

PHARMACY INFORMATION

NAME OF THE PHARMACY _____

TEL/ADDRESS OF PHARMACY _____