William Langston, MD
Caroline M. Tanner, MD, PhD
James W. Tetrud, MD
Melanie M. Brandabur, MD, MDS
Grace S. Lin Liang, MD

Greetings,

This letter is to welcome you to our Clinic, the Movement Disorders Treatment Center, at the Parkinson's Institute.

Enclosed are our patient registration forms. Please complete these forms to the best of your knowledge, return them prior to your appointment. Please check in at the clinic thirty minutes prior to your scheduled appointment time.

Also, please read the *Notice of Privacy Practices* and the *Patient Consent Form*. If you agree to our Clinic policies and you would like to be treated by one of our Doctors, please sign and date the *Patient Consent Form*. You may use the *Patient Consent Form* to specify any restrictions on our communications and list additional contact phone numbers.

Please bring your insurance cards to be copied. Insurances we currently contract with are Blue Shield of California PPO, Anthem Blue Cross, United Healthcare, Aetna and Medicare Part B. If you have Medicare coverage, we will bill Medicare for you and we do accept assignment. If you have other types of insurance, we will bill your insurance companies to assist you in getting reimbursed. Please read the *Patient Financial Agreement Form* and if you agree to our Clinic visit policies, sign and date this enclosed form. **Self-paying patients are required to pay at the time of service.**

Your evaluation will take approximately 90 minutes. It will consist of the physician taking a medical history and assessing current medical problems, as well as performing a comprehensive medical test which includes a neurological examination.

We are located at **675 Almanor Avenue** in **Sunnyvale, California**. There is plenty of parking for your convenience. If you have any questions, please feel free to call **(408) 734-2800** to reach the clinic.

We look forward to meeting you!

Patient Questionnaire

Mr. / Mrs. / Ms. / Dr. ☐M ☐F

Last Name First Middle Today's Date

Birth Date Social Security Number Current Employer Employer Address

Home Address City State Zip Code

( ) ( )

Home Phone number Daytime/Other Phone number E-mail

May we leave a voicemail message? ☐Yes ☐No ☐Yes, but leave only call back number

Marital Status: ☐Single ☐Married/partner (Name:_____________________) ☐Divorced ☐Widowed

( )

Person allowed to receive/discuss your medical information (optional) Relationship Telephone number

( )

Emergency contact person Relationship Telephone number

Race (optional): ☐White ☐African-American ☐Hispanic ☐Asian/ Pacific Islander ☐Other_______

Primary Insurance Information:		**Secondary Insurance Information:**	
Subscriber's name		Subscriber's name	
Insurance co. name	Effective Date	Insurance co. name	Effective Date
Plan type (circle): PPO EPO HMO MC Private		Plan type (circle): PPO EPO HMO MC Private	

*If your insurance plan is EPO, MC, or HMO, it will require a prior authorization.

Please fill out the following and **check off** the contacts to whom you would like us to send the report.

☐Primary care doctor Name:		☐ Neurologist Name:		☐Other Name:	
Street address		Street address		Street address	
City		City		City	
State	Zip Code	State	Zip Code	State	Zip Code
Telephone ( )		Telephone ( )		Telephone ( )	

Name of referring physician:____

Symptomatic History:
Reason for today's visit (diagnosis?):____________________________ Date of diagnosis:__________

What was/were your first symptom(s)? ___________________________ When did it occur?__________

Who diagnosed you with the above condition(s)? ☐Primary Care Physician ☐Neurologist ☐Other____

Medical History:

Do you have other medical problems or illnesses requiring treatment? ☐No ☐Yes (describe):

Past:____

____

____

Current:

____

____

____

Surgeries, significant trauma, or hospitalizations? ☐No ☐Yes (please describe, indicate year):

____

____

____

Social History:

Years of education/highest degree_______ ☐ Most recent/primary occupation ___________________

☐ Currently working ☐ Retired (year)____________

Living situation: ☐At home (with:___________) ☐Assisted living ☐Nursing facility ☐Board and care

Smoking: ☐ Never ☐ Yes ☐ Yes, but Quit (date: _________________)

*If yes - ☐ Cigarettes per day: _______ and # of years: _______

Alcohol: ☐ Never ☐ Yes ☐ Yes, but Quit (date: _________________)

*If yes - ☐ Drinks/ week: ________ and # of years: _______

Recreational Drugs: ☐ Never ☐ Yes (describe): ______________________________________

Are you currently driving? ☐ No ☐ Yes

Family History: Please indicate family members (parents, siblings, children, grandparents, aunt/uncles/cousins) with any of the following medical conditions:

Parkinson's disease	Diabetes
Tremor	Thyroid disease
Alzheimer's or other dementia	Cancer, specify type
Tourette/tic disorder	High blood pressure
Other movement disorder/genetic disorder	High cholesterol
Other neurological condition	Stroke
Depression/suicide	Heart disease
Mental illness	Other

Activities of Daily Living: Please indicate if you have difficulty in the following areas.

	Normal	**Mild** (infrequent, no help needed)	**Moderate** (occasional, may need some help)	**Severe** (frequent, requires assistance)	**Marked** (very frequent, unable to do)
Voice/Speech					
Excess saliva					
Swallowing					
Handwriting/Typing					
Feeding					
Dressing					
Bathing/toileting, hygiene					
Turning in bed					
Walking					
Handling medications					
Shopping					
Cooking, household chores					
Handling finances, bills					
(Tremor, pain?)					

Review of Symptoms: Please check any current symptoms you have.

COGNITION:
__Dementia
__Word finding difficulty
__Impaired memory
__Confusion / disorientation
__Slow processing
__Stable

PYSCH:
__Anxiety
__Panic attacks
__Vivid dreams / nightmares
__Hallucinations / Illusions

__OCD
__Mood swings / irritable
__Stable

SLEEP:
__Insomnia
__Sleep Apnea / pauses in breathing
__Snoring
__Acting out dreams
__Excessive daytime sleepiness
__Restless Leg Syndrome
__Talking / Yelling out in sleep

SPEECH :
__Hoarse
__Soft
__Difficult to hear

SWALLOW:
__Excessive saliva
__Dry mouth
__Drooling
__Choking

GASTROINTESTINAL:
__Constipation

__Diarrhea
__Reflux
__GERD
__Incontinence

__Gas / Bloating

ENT:
__Loss of smell / taste
__Hearing loss
__Vertigo
__Dizziness
__Congestion

SENSORY / MUSCULOSKELETAL:
__Arthritis / joint pain
__Back / neck pain
__Numbness / tingling of______
__Muscle cramps / Spasms /Tightness
__Burning sensation
__Headache

__**GAIT & BALANCE**
__Slow gait
__Impaired balance
__Falls
__Freezing
__Cane / walker / wheel chair

__**RESPIRATORY:**
__Wet / Dry cough
__Chest tightness
__Shortness of breath
__Asthma

CONSTITUTIONAL / ENDOCRINE:
__Fatigue/weakness
__Cold/heat intolerance
__Diabetes
__Fever
__Sweating
__Unexplained weight loss or gain __

Handwriting Exam

Name:_________________________ Date:_____________

☐ Right handed

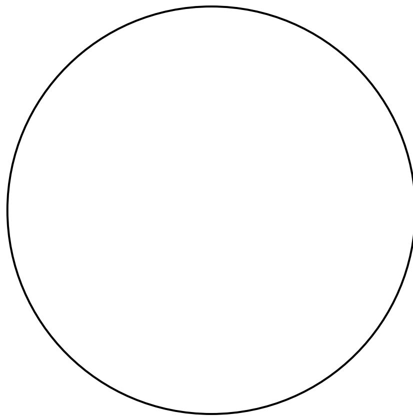
☐ Left handed

Sign your name:

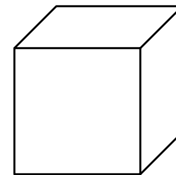
Please write the following: "Today is a nice day."

Write any sentence you would like, as long as it is a complete sentence.

Put in the numbers of the clock



Copy this shape



Draw the clock's hands to show 7:15

Medication List
(include all over the counter medications and supplements, use more paper if necessary)

Name: ____ Date: ______________________________

- Please list all the medications that you are currently taking and all of the previous medications that you have tried but discontinued.
- Include strength, the time(s) that you are taking them each day, and the number of tablets at each time.

EXAMPLE

		Time	Time	Time	Time	Time	Time	Time	Time
Current Medications/	Strength (mg)	8:00 am	12:00 pm	4:00 pm	8:00 pm	: am/pm	: am/pm	: am/pm	: am/pm
Sinemet	25/100	1 pill	2 pills	1 pill	2 pills				

	Time	Time	Time	Time	Time	Time	Time	Time
Current Medications/ Strength (mg)	: am/pm	: am/pm	: am/pm	: am/pm	: am/pm	: am/pm	: am/pm	: am/pm
Previous Medications/ Strength (mg)	: am/pm	: am/pm	: am/pm	: am/pm	: am/pm	: am/pm	: am/pm	: am/pm

Allergies

Are you allergic to any medications? ☐No ☐Yes (if yes - describe allergies and reactions)

____

____

____

Patient Consent Form
(to the Use and Disclosure of Health Information
for Treatment, Payment, or Healthcare Operations)

I, ____________________, understand that as part of my health care, The Parkinson's Institute (TPI) originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as a:

- Basis for planning my care and treatment
- Means of communication among many health professionals who contribute to my care
- Source of information for applying my diagnosis and surgical information to my bill
- Means by which a third-party payer can verify that services billed were actually provided
- Tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

In order to provide high-quality services, activities that TPI carries out include: appointment reminder telephone calls and postcards, videotape and photograph, returning patient phone calls, referrals to other physicians, and sending medical records to transcription services, other physicians' offices, insurance companies, state agencies, the patient, and designated relatives.

TPI wants to keep patients and their families and caregivers updated on latest developments. Patient support is paramount to the Parkinson's Institute. Thus, newsletters will be mailed regularly and patients will be placed on a donations database, unless specified otherwise. To determine eligibility for upcoming clinical trials and patients will be placed into a Clinical Trials database, unless specified otherwise.

I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I wish to have the following restrictions to the use or disclosure of my health information:

____

____

____

____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by this rule.

I understand that the Parkinson’s Institute is not required to agree to the restrictions requested. I understand that I may revoke this consent by writing to the *Privacy Officer, Renee Rodriguez,* except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that the Parkinson’s Institute reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should the Parkinson’s Institute change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I fully understand and ☐accept / ☐decline the terms of this consent. I acknowledge that I have received and reviewed the *Notice of Privacy Practices*.

____ ____________________

Patient's Signature Date

Notice of Privacy Practices

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

Introduction:
At the Parkinson's Institute, we are committed to treating and using protected health information about you responsibly. The Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) require us to continue maintaining the confidentiality and security of your information. This *Notice of Privacy Practices* describes the personal information we collect and how and when we use or disclose that information. It also describes your rights as they relate to your Protected Health Information (PHI). This Notice is effective March 1, 2003, and remains in effect until we replace it. It applies to all Protected Health Information as defined by federal regulations.

Understanding Your Health Record/Information:
Each time you visit the Parkinson's Institute, a record of your visit is made. Typically, this record contains your symptoms, examination, test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing, and
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights:
Although your health record is the physical property of the Parkinson's Institute, the information belongs to you. You have the right to:

- Consent to use your PHI for Treatment, Payment, or healthcare Operations (TPO),
- Provide a written authorization for other uses and disclosures not identified by this notice or permitted by applicable law,
- Delegate another person the authority to consent to, or authorize disclosure of PHI,
- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record for a reasonable, cost-based fee, as provided for in 45 CFR 164.524. (Submit requests in writing to the Privacy Officer. The request will be processed within 30 days),
- Amend your health record if you believe that it is incorrect or incomplete as provided in 45 CFR 164.528. S. Submit requests in writing to the Privacy Officer, with a reason that supports the request. The physician must make the amendment within 60 days. If the physician denies the request, you may write an objection to the denial, and require that all communications be documented and attached to future disclosures of PHI,
- Obtain an accounting of non-routine, non-TPO disclosures of your health information after implementation of the Privacy Act for a reasonable, cost-based fee as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided in 45 CFR 164.522. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you,
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Copies of these federal regulations are available through the Privacy Officer.

Our Responsibilities:
The Parkinson's Institute is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice, which is now in effect,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain, including information previously created or received before the effective date. Should our information practices change, we will mail a revised notice to the address you have supplied us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem:
If have questions and would like additional information, you may contact the Parkinson's Institute's Privacy Officer**, Renee Rodriguez at (408) 734-2800.**

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address is: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201

Examples of Disclosures for Treatment, Payment and Healthcare Operations:
We will use your health information for treatment.
For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you are discharged.

We will use your health information for payment.
For example: A bill may be sent to you or a third-party payer. The information accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.
For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality of the healthcare and service we provide.

Business associates: There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department, radiology, certain laboratory offices, and a billing service we use. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers (when their research has been approved by an institutional review board, that has reviewed the research proposal and established protocols to ensure the privacy of your health information).

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs (for the purpose of tissue donation and transplant).

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fundraising: We may contact you as part of a fund-raising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability, including child abuse and neglect.

Victims of abuse, neglect, or domestic violence: We may disclose PHI to appropriate authorities if we find reasonable belief that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your PHI if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We will only make disclosures to a person or organization able to prevent the threat.

Correctional institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena or court order. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Specialized government functions: Subject to certain requirements, we may use or disclose PHI for military personnel and veterans to federal officials for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

The Parkinson's Institute and Clinical Center

One - Time
Patient Financial Agreement

I ________________________________ hereby authorize **The Parkinson's Institute**
PATIENT'S FULL NAME (PLEASE PRINT)
(TPI) **and Clinical Center** to apply for benefits on my behalf for services rendered. I certify that the information I have reported with regard to my insurance coverage is correct, and further authorize the release of any necessary information, including medical information, for this or any related claim to my insurance company in order to determine these benefits payable. I request that payment of authorized benefits be made payable to The Parkinson's Institute and Clinical Center on my behalf.

1. The Parkinson's Institute and Clinical Center is a participating provider with Medicare, Blue Shield of California (PPO only), PHCS, Interplan, and First Health. By contract, covered charges will be paid directly to TPI and Clinical Center. I understand that any applicable co-insurance or deductible payments are my responsibility. These will be billed to me after my insurer has considered the claim.

2. The Parkinson's Institute and Clinical Center is not a provider to any HMO programs. I understand that if I am an HMO participant/patient, I am responsible for obtaining an authorization from my primary care physician prior to my visit(s). If I have not obtained authorization for my initial or any subsequent visit(s), I will be required to pay at the time of service.

* If you are not sure what your insurance covers please call your insurance carrier prior to your visit.

* It is your responsibility to inform The Parkinson's Institute of any changes to your medical insurance policies.

3. I understand that I am financially responsible for all non-covered, non-authorized or denied charges incurred on my behalf.

4. A copy of this agreement may be used in place of the original. This is a one-time agreement and shall remain in effect while I am a patient in the Movement Disorders Clinic at The Parkinson's Institute.

________________________________ ____________________
Patient's Signature Date

The Parkinson's Institute and Clinical Center
675 Almanor Avenue, Sunnyvale, CA 94085

Toll Free phone numbers:
In California: 800.655.2273
Outside California: 800.786.2958

Fax number: 408.734.9208
Clinic: 408.542.5697

DIRECTIONS TO THE INSTITUTE:

From San Jose -
> Take US-101 N. toward San Francisco
> Take the MATHILDA AVENUE SOUTH exit (toward Sunnyvale)
> At first stoplight, IMMEDIATELY turn RIGHT onto ALMANOR AVE. The Institute is on the RIGHT approximately 1/4 mile.

From Palo Alto -
> Take US-101 S toward San Jose.
> Take the MATHILDA AVENUE exit (stay to the right)
> At first stoplight, IMMEDIATELY turn RIGHT onto ALMANOR AVE. The Institute is on the RIGHT approximately 1/4 mile.

From Highway 237 West (from Milpitas) -
> Take the MATHILDA AVE exit toward US-101 S / SUNNYVALE.
> Turn LEFT onto N. MATHILDA AVE.
> Turn RIGHT onto ALMANOR AVE. The Institute is on the RIGHT approximately 1/4 mile.

From Highway 237 East (from Mountain View) -
> Exit onto N. MATHILDA AVE (make a right onto N. Mathilda Ave.) toward Sunnyvale.
> Turn RIGHT onto ALMANOR AVE. The Institute is on the RIGHT approximately 1/4 mile.

If you get stuck or need assistance, call us at 408.734.2800 - the receptionist will help you.

Motels in close proximity to our Institute

* Call for current rates – these may be out of date

Name	Address	City	Rates*	Phone
Best Western	4341 El Camino Real	Santa Clara	$90-120	408.244.3366
Best Western Silicon Valley Inn	600 Mathilda Ave.	Sunnyvale	$100-120	408.735.7800
Maple Tree Inn	711 El Camino Real	Sunnyvale	$120-160	408.720.9700
Motel 6	3208 El Camino Real	Santa Clara	$55-70	408.241.0200
Sunnyvale Fairoaks Inn	385 Weddell Drive	Sunnyvale	$60-90	408.734.9700
Value Inn	852 W. El Camino Real	Sunnyvale	$90-100	408.773.1234
Comfort Inn	595 N. Mathilda Avenue	Sunnyvale	$90	408.749.8000
Howard Johnson Inn	2499 El Camino Real	Santa Clara	$109-150	408.244.9610
Friendship Inn	958 E. El Camino Real	Sunnyvale	$99-159	408.733.8800
Sundowner Inn	504 Ross Drive	Sunnyvale	$90-139	408.734.9900 800.223.9901
Quality Inn	1280 Persian Drive	Sunnyvale	$69-109	408.744.0660
Westin Hotel	5101 Great America Parkway	Santa Clara	$250+	408.986.0700
Sheraton Inn	1100 N. Mathilda Avenue	Sunnyvale	$249+	408.745.6000
Doubletree Inn	2050 Gateway Place	San Jose	$189-289	408.453.4000

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Caroline M. Tanner, MD, PhD
James W. Tetrud, MD
Melanie M. Brandabur, MD, MDS
Neng C. Huang, MD, PhD
Grace S. Lin Liang, MD

Request for Medical Records

To: ____

____

____

Please release my medical records to:

The Parkinson's Institute and Clinical Center, 675 Almanor Avenue, Sunnyvale, CA 94085
Phone: (408) 734-2800 Fax: (408) 734-9208

Records pertaining to the diagnosis of ____________________________:

- Original History & Physical
- Most recent History & Physical
- MRI reports and films
- Recent laboratory reports
- Consultation reports
- Past year's doctors' notes (including muscle testing & UPDRS)

Purpose of Disclosure:

☐ New patient referral ☐ Continuity of care ☐ Other _____________

Date of Expiration: This authorization shall remain in effect until __________ or for one year from the date of signature.

Revocation of Request: This authorization is also subject to written revocation by the undersigned at any time between now and disclosure of information by the disclosing party. My written revocation will be effective upon receipt, but will not be effective to the extent that the request or others have acted in reliance upon this authorization.

Minimum Necessary Standard: The Protected Health Information requested is the minimum necessary to accomplish the specified purpose.

____________________________________ ____________________

Patient's Printed Name Date of Birth

____________________________________ ____________________

Patient's Signature (or Legal Representative) Today's Date