



6133 POPLAR PIKE AT RIDGEWAY  
MEMPHIS, TN 38119

**Tel: (901) 761-9720 Toll Free: (800) 477-SHEA Fax: (901) 415-6617 Email: [gregory.staffel@sheaclinic.com](mailto:gregory.staffel@sheaclinic.com)**

Thank you for entrusting us with your medical care. Your appointment is with **Dr. J. Gregory Staffel**.

First, please fill out the requested information and answer the relevant questions on the Shea Clinic patient portal. Otherwise, please complete the accompanying forms before arriving and if possible fax them to (901) 415-6617. This will enable us to key your information into the computer before you arrive. If you cannot do this, then please arrive 30-45 minutes early in order to give us time to do this before your appointment.

Here is a checklist of things to do before your visit:

- Please fill out any relevant questionnaires included in this packet.
- Please get the phone and fax numbers of your primary care physicians, your referring physicians and any other physicians with whom you will want us to communicate (see form).
- We would like to have the phone number of your pharmacy (see form). This may be easily found on any bottle of medicine from that pharmacy.
- Please read any information brochures / handouts accompanying this letter if they are relevant.
- If you have had a CT scan (usually of your sinuses), it is best to bring a copy of the scan (not just the report) with you. (They never seem to arrive if you just call and have them sent).
- If you have had a sleep study, either bring a copy with you or fax us back the name and number of the sleep lab, along with a signed authorization to obtain the results.
- If your appointment is for allergy testing, please **STOP** using **ALL** antihistamines (such as Claritin, Allegra, Zyrtec or Benadryl) for one (1) week prior to your appointment.

Once the paperwork is done, I will talk with you about your symptoms and perform a head and neck examination. First, I will place some medicine (Afrin® and lidocaine) in your nose to shrink and numb the membranes. Then, I will look in your ears, mouth and throat. I will examine your neck to see if there are any masses. Finally, I will examine your nose and sinuses. If you need it, I will pass a small telescope into your nose to examine the internal structures, as well as the openings to the sinuses. If you have a throat or voice problem, and I cannot perform an adequate examination with a mirror, then I will pass a small flexible telescope through your nose and into your throat. These examinations do not hurt.

After the examination, we will discuss my initial diagnosis, and the various options we have for treatment.

The physicians of Shea Clinic participate in Medicare, Blue Cross/Blue Shield and most other Commercial Insurance plans. **Shea Clinic does NOT participate in any MEDICAID plans, and is NOT accepting any new MEDICAID patients. Shea Clinic does NOT participate with TENNCARE or most HMO Plans.** You are responsible for paying any co-pays, coinsurance and/or deductibles based on your insurance's contracted rates. Please check with your insurance company to learn if Shea Clinic participates in your plan. **If Shea Clinic is not a participating provider in your insurance plan, you may or may not have out-of-network benefits.** Regardless, you will be responsible for paying any deductibles and/or coinsurance at the time of service. If you do not have any out-of-network benefits, you will be considered a "self-pay" patient. **Self-pay patients are required to pay a \$500.00 deposit before services are rendered. If your insurance plan requires a referral, you must obtain this referral prior to your appointment date.**

Most Shea Clinic patients stay at the Sonesta Suites connected to the Shea Clinic by a walkway. The telephone number is (800) 766-3782 and be sure to ask for the special discount rate for Shea Clinic patients. A listing of additional nearby hotels is listed on our website ([www.SheaClinic.com](http://www.SheaClinic.com)). These hotels may or may not offer a special "Shea" rate. For your convenience, there is also a map with directions posted on our website.

**PLEASE** do **NOT** bring children or more than one responsible adult with you. If you are coming from out of town and are recommended for surgery, you will need one responsible adult with you should you decide to schedule your treatment for the next day. Otherwise, you will need to schedule your surgery at some point in the future when you will be accompanied by a responsible adult.



## J. GREG STAFFEL, M.D.

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A native of Texas, Dr. Staffel brings a wealth of experience and a diversity of expertise to his practice at the Shea Ear Clinic.

In his early years, his extensive travels in Europe led to a great understanding of cultural diversity as well as a fluency in French. While initially interested in engineering, his commitment to greater giving led him to medicine. Attending medical school at the University of Texas in San Antonio, Dr. Staffel graduated with honors. During this time, Dr. Staffel attended a lecture that profoundly influenced his career. When first exposed to facial plastic surgery, especially rhinoplasty, he began a lifelong pursuit of learning, teaching and practicing nasal and facial plastic surgery.

He trained for five years during his residency at the University of North Carolina, earning the Nathan A. Womack Award, given to the most promising surgical resident. Following his residency, he completed a fellowship at the American Academy of Facial Plastic and Reconstructive Surgery under Dr. Richard Farnier, an original pioneer in cosmetic nasal and facial surgery. After his fellowship, Dr. Staffel was immediately offered numerous academic positions throughout the country and accepted an Assistant Professorship at the University of Texas Medical School at San Antonio. There, he worked closely with the best nasal plastic surgeons in the world, perfecting his technique.

Grateful for his own learning experiences, Dr. Staffel went on to write and publish "Basic Principles of Rhinoplasty" which is endorsed by the American Academy of Facial Plastic and Reconstructive Surgery and provided to every otolaryngology resident training in the U.S. During his academic career, he also authored "Primary Care Otolaryngology" which is currently part of medical student curriculum. Dr. Staffel's natural passion for teaching and his clinical experience has earned him many awards from peers and students.

Dr. Staffel joined the Shea Ear Clinic in 1998, and has a busy practice in general otolaryngology and facial plastic surgery. His special interests include nasal and facial plastic surgery, sinus surgery, cosmetic nasal surgery, face lifts, eye lifts, liposuction, chemical peels and skin care. His expertise also covers cosmetic and reconstructive surgery of the external ear. In addition, he also sees patients for allergy, snoring, and sleep apnea.

Dr. Staffel is married to Marian, and they have a son, John, and two labs, Charlie and Zoe.

**PATIENT INFORMATION**

Date: \_\_\_\_\_

Pharmacy: \_\_\_\_\_  
Name Address Phone

Patient's Name: \_\_\_\_\_  
Last Middle First

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ SSN: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Language: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Home # (\_\_\_\_) \_\_\_\_\_ Work # (\_\_\_\_) \_\_\_\_\_ Cell# (\_\_\_\_) \_\_\_\_\_

Fax#(\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

**EMPLOYMENT INFORMATION:**

Current Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer's Address: \_\_\_\_\_  
Street City State Zip

If retired, give last employer and occupation: \_\_\_\_\_ When did you retire? \_\_\_\_\_ **Year**

If disabled, who declared you disabled and for what reason? \_\_\_\_\_

**SPOUSE INFORMATION:**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Employer: \_\_\_\_\_ Work #: \_\_\_\_\_ Occupation: \_\_\_\_\_

**EMERGENCY CONTACT:**

Relative or Friend not living at the same address: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Name Telephone Relationship

**PRIMARY INSURANCE INFORMATION:**

\_\_\_\_\_  
Name of Insurance Co. Individual Policy No. Name of Insured

\_\_\_\_\_  
Street Address Group Policy No. Relationship to Patient

\_\_\_\_\_  
City, State, Zip Insured's Date of Birth Insured's Soc Sec Number

**SECONDARY INSURANCE INFORMATION:**

\_\_\_\_\_  
Name of Insurance Co. Individual Policy No. Name of Insured

\_\_\_\_\_  
Street Address Group Policy No. Relationship to Patient

\_\_\_\_\_  
City, State, Zip Insured's Date of Birth Insured's Soc Sec Number

**OTHER DOCTORS INFORMATION:**

Referring Doctor: \_\_\_\_\_ Telephone #: (\_\_\_\_\_) \_\_\_\_\_

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

Local General Doctor: \_\_\_\_\_ Telephone #: (\_\_\_\_\_) \_\_\_\_\_

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

Cardiologist: \_\_\_\_\_ Telephone #: (\_\_\_\_\_) \_\_\_\_\_

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

Certain tests are often required prior to being seen by your doctor. If you are the patient or are responsible for the patient, do you consent to have these tests performed on you or any child or other adult for whom you are responsible?

\_\_\_\_\_ Yes                      \_\_\_\_\_ No                      Signature: \_\_\_\_\_

**ASSIGNMENT OF BENEFITS:**

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government or medical benefits to the party who accepts assignment.

\_\_\_\_\_  
Guarantor's Signature                      Relationship to Patient                      Date                      Witness

**PATIENT RESPONSIBILITIES**

1. Provide accurate and complete information about the present complaint, past illnesses, hospitalizations, medications, and other matters which relate to their health.
2. Report their level of pain or unexpected changes in their condition.
3. Report whether they clearly understand plans for their care and what is expected of them.
4. Follow both the treatment plan recommended by the physician and the Shea Clinic rules and regulations affecting their care and conduct, including the instructions of nurses and other health professionals.
5. Accept the outcome of their actions should they refuse treatment or choose not to follow the physician's order.
6. Be considerate of the rights of other patients and Shea Clinic staff and for assisting with the control of noise.
7. Be respectful of the property of other persons and of the Shea Clinic.
8. Meet all of the financial obligations of their health care.

**PHYSICIAN REFERRAL POLICY**

If the patient's insurance requires a physical referral, the referring physician must call your insurance company and obtain a referral authorization prior to your appointment. It is the patient's responsibility to bring their referral information with them, or have their referring physicians send the referral letter by mail or fax to:

**SHEA CLINIC  
6133 POPLAR PIKE  
MEMPHIS, TN 38119  
FAX: (901) 683-8440**

**PRE-CERTIFICATION POLICY**

Shea Clinic has adopted the following policy for pre-certification on all insurance plans, health maintenance organizations and other reimbursement plans excluding Medicare:

1. When provided with complete insurance carrier information at admission, we will assist patients in pre-certifying their admission and stay as directed by their insurance company. Patients should contact their employer if they are unsure of their policy requirements regarding pre-certification.
2. Regardless of the outcome of pre-certification efforts, Shea Clinic will NOT be financially responsible for any reduction in payment or any penalty sustained by the patient or the guarantor. Nor will Shea Clinic accept responsibility for pre-certification. Any failure of Shea Clinic personnel to assist in this process will NOT make the Shea Clinic financially liable.
3. Shea Clinic will hold the patient, or guarantor, responsible for all balances not paid by the patient's insurance company, HMO or other insurance reimbursement plan, regardless of the conditions of pre-certification, or the outcome of the process.
4. Shea Clinic acknowledges the pre-certification process may often be a complex and labor intensive exercise. With a vast multitude of insurance companies, insurance plans within the insurance companies, and other less traditional reimbursement plans, it is the patient's and/or the guarantor's responsibility to know the requirements of their policy. As the owner of the policy, it is imperative the guarantor understand all of the parameters of the plan they own. Accordingly, Shea Clinic will not be held financially responsible when the plan requirements are not fulfilled to the satisfaction of ANY third party payor.



# SHEA EAR CLINIC

EAR, NOSE AND THROAT

## PATIENT FINANCIAL POLICY

The Shea Clinic is a participating provider with many managed health care insurers to accommodate the needs of our patients.

We are committed to building a successful physician-patient relationship with you. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment of services is a part of the relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, phone number, insurance information, etc.).

### Insurance Claims & Co-Pays

The patient must present an insurance card at each visit. All co-payments, co-insurance, deductibles and past due balances are due at the time of checkout. Insurance is a contract between you and your insurance company. Insurance programs have many individual requirements and the same insurance company may have different benefits based upon the employer group or individual policy.

If your insurance company has special requirements for your services, such as a special lab requirement, a limitation on the number of times a service can be performed, limitations on where outpatient services may be performed, or requirements for primary care referrals, you must advise our office of these provisions or you may be responsible for additional charges. The Shea Ear Clinic makes every attempt to minimize your out-of-pocket costs by following any provisions of which you make us aware.

Although we may estimate what your insurance company will pay, the insurance company makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, it is your responsibility to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance.

### Referrals and Prior Authorizations

If your insurance company requires a referral and/or prior authorization, you are responsible for obtaining it. Failure to obtain the referral and/or prior authorization may result in a lower or no payment from insurance, and the balance will be your responsibility.

### Self-Pay Accounts

Self-Pay accounts are patients without insurance coverage or patients without any out-of-network benefits. Self-pay patients are required to pay a \$500.00 deposit before services are rendered. All guarantors are required to provide proof of their social security number or provide the Shea Ear Clinic with a \$500.00 deposit before services are rendered.

### Missed Appointments

The Shea Clinic requires a 24-hour notice of appointment cancellation. Appointments missed and are not previously cancelled may be charged a fee of \$25.00 in which case this fee must be paid prior to scheduling additional appointments.

### Returned Checks

The charge for a returned check is \$40.00, payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a "cash-only" payment basis following any returned check.

### Outstanding Balance Policy

It is our office policy that all past due accounts be sent two statements. In the event an account is turned over for collection, the person financially responsible for the account will be responsible for all collection costs, including attorney fees and court costs.

### Medical Records Policy

The Shea Clinic will provide your medical records to a referred physician as a courtesy. Any other requests will require the prepayment of a \$20.00 retrieval fee plus \$.40 per copied page. This fee is subject to change without notice at any time.

### Forms Completion Policy

Requests for the Shea Clinic, our physicians or members of our staff to complete forms will require the prepayment of a \$20.00 retrieval fee plus \$25.00 per page. This fee applies to all requests for the completion of any disability papers or consultation forms.

I accept and understand the Shea Clinic Financial Policy.

\_\_\_\_\_  
Guarantor Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Guarantor

\_\_\_\_\_  
Witness



**NEW PATIENT VISIT/CONSULTATION**

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

What do other people call you? \_\_\_\_\_ Who referred you to Shea Ear Clinic? \_\_\_\_\_

Reason for today's visit? \_\_\_\_\_

Have you ever been diagnosed with any of the following diseases?

	Yes	No		Yes	No
Asthma	___	___	Diabetes	___	___
Kidney Disease	___	___	Thyroid Disease	___	___
Lupus	___	___	Lung Disease	___	___
Bleeding Tendencies	___	___	Nervous System Problems	___	___
Heart Disease	___	___	Tuberculosis	___	___
Epilepsy	___	___	Osteoarthritis	___	___
High Blood Pressure	___	___	Alcoholism	___	___
Hepatitis	___	___	Sickle Cell Disease	___	___
Rheumatoid Arthritis	___	___	Colitis	___	___
Anemia	___	___	Stomach Ulcers	___	___
Cancer	___	___	Sarcoidosis	___	___
High Cholesterol	___	___	Depression/Anxiety	___	___
Gastric Reflux	___	___	Obstructive Sleep Apnea	___	___
Other medical conditions? _____					Are you on CPAP? _____

List all operations that you have had: (i.e. ear surgery, tonsils, hernias, appendix, gallbladder, etc.)

<u>Procedure</u>	<u>Date</u>	<u>Complications</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all current medications, dosages, and how many times per day.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you allergic to any medications/drugs? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please list all drug allergies below and your reaction to each.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

Do you smoke or use tobacco? \_\_\_\_\_ What form? \_\_\_\_\_

How much per day? \_\_\_\_\_ For how long? \_\_\_\_\_

Do you drink alcohol? Yes \_\_\_\_\_ No \_\_\_\_\_ Beer \_\_\_\_\_ Wine \_\_\_\_\_ Other \_\_\_\_\_

How much? \_\_\_\_\_ For how long? \_\_\_\_\_

Do you drink coffee or tea? \_\_\_\_\_ How much per day? \_\_\_\_\_ Do you use much salt in your diet? \_\_\_\_\_

How many children do you have? \_\_\_\_\_ What are their ages? \_\_\_\_\_

Have you ever worked around loud noise? \_\_\_\_\_ Doing what? \_\_\_\_\_ For how long? \_\_\_\_\_

Has anyone in your family had:

High Blood Pressure \_\_\_\_\_ Heart Disease \_\_\_\_\_ Diabetes \_\_\_\_\_

Bleeding Problems \_\_\_\_\_ Lung Disease \_\_\_\_\_ Stroke \_\_\_\_\_

Cancer (explain who and what type): \_\_\_\_\_

Are your parents living? \_\_\_\_\_ What are their ages now, or when they died? \_\_\_\_\_

Have you recently had the following:

	Yes	No		Yes	No
Chest Pain	___	___	Nausea/Vomiting	___	___
Breathing Difficulties	___	___	Loss of Control of Bowels	___	___
Numbness/Tingling	___	___	Blood in Urine	___	___
Vision Changes	___	___	Fainting Spells	___	___
Abdominal Pain	___	___	Cough with Blood	___	___
Bloody/Tarry Stools	___	___	Headaches or Migraines	___	___
Pain/Burning Urination	___	___	Unexpected Weight Loss	___	___
Irregular Heartbeat	___	___	Diarrhea	___	___
Cough	___	___	Difficulty Starting Urination	___	___
Dizziness	___	___	Loss of Bladder Control	___	___
Fever or Chills	___	___	Sinus Disease	___	___

Please explain further any "YES" answers. \_\_\_\_\_

**Have you had a CT scan of the head?** Yes \_\_\_ No \_\_\_ Approx. Date: \_\_\_\_\_ Result: \_\_\_\_\_

**Have you had an MRI of the head?** Yes \_\_\_ No \_\_\_ Approx. Date: \_\_\_\_\_ Result: \_\_\_\_\_

**Do you currently have problems, or do you have a history of having problems, with your sinuses or allergies?** \_\_\_\_\_  
( Notice! If the answer to the above is "No" or "Not Applicable" there is no need to complete the rest of this form )

**How long have you had problems with your sinuses or allergies?** \_\_\_\_\_

**Which of the following symptoms do you seem to have all the time?**

- |  |                                      |  |
|--|--------------------------------------|--|
| <input type="checkbox"/> Nasal obstruction   | <input type="checkbox"/> Cough       | <input type="checkbox"/> Sneezing      |
| <input type="checkbox"/> Post nasal drainage | <input type="checkbox"/> Sore throat | <input type="checkbox"/> Nasal itching |
| <input type="checkbox"/> Watery/itchy eyes   | <input type="checkbox"/> Hoarseness  | <input type="checkbox"/> Nosebleeds    |

**Which of the following symptoms typify your episodes of acute sinusitis?**

- |   |  |                                      |
|---|--|--------------------------------------|
| <input type="checkbox"/> Facial pain/pressure | <input type="checkbox"/> Post nasal drainage | <input type="checkbox"/> Cough       |
| <input type="checkbox"/> Headache             | <input type="checkbox"/> Bad breath          | <input type="checkbox"/> Fever       |
| <input type="checkbox"/> Nasal obstruction    | <input type="checkbox"/> Toothache           | <input type="checkbox"/> Sore throat |

**How many times per year do you typically get a sinus infection requiring antibiotics?**

- Never                       1-3                       3-5                       > 5

**Are your symptoms:**  About the same all year     Usually worse in the spring and fall

**Have you ever been tested for allergies in the past?**  No                       Yes, skin test                       Yes, blood test

**If yes, what year?** \_\_\_\_\_ **What were you allergic to?**  Dust  Cats  Dogs  Pollen  Mold  Grass  Trees

**Did you ever take allergy shots?**  No  Yes **If yes, for how long?** \_\_\_\_\_ **When did you stop?** \_\_\_\_\_

**Have you found any medications which seem to help your symptoms?** \_\_\_\_\_

**What medications have you taken in the past?**

- Antihistamines     Decongestants                       Intranasal Steroid Sprays                       Over the counter medications                       Cromolyn  
(Zyrtec, Claritin)    (Sudafed, Zyrtec-D)    (Flonase, Nasonex, Nasacort)

**Have you ever had asthma?**  No  Yes                      **Have you ever had nasal polyps?**  No  Yes

**Have you had a CT scan of your sinuses?**

No     Yes    Approximate Date \_\_\_\_\_    Result \_\_\_\_\_

**The above information is accurate to the best of my knowledge.**

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date





**Medical Information Release Form**  
**(HIPAA Release Form)**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Yes\_\_\_ No\_\_\_ I hereby authorize the Shea Ear Clinic to communicate my medical information including the diagnosis, records; examination rendered to me and billing information. This information may be released to the following individuals:

1. Name \_\_\_\_\_ Phone # \_\_\_\_\_  
Relationship \_\_\_\_\_ Alternate # \_\_\_\_\_

2. Name \_\_\_\_\_ Phone # \_\_\_\_\_  
Relationship \_\_\_\_\_ Alternate # \_\_\_\_\_

**Messages**

Yes\_\_\_ No\_\_\_ I give permission to leave messages on my answering machine/voice mail (Test Results or Appointment information). Phone # \_\_\_\_\_  
Alternate # \_\_\_\_\_

Yes\_\_\_ No\_\_\_ I give permission to communicate with me via texting and email (Test Results or Appointment information). Cell # \_\_\_\_\_  
Email \_\_\_\_\_

Yes\_\_\_ No\_\_\_ I give permission to call my place of employment. Phone # \_\_\_\_\_

Yes\_\_\_ No\_\_\_ I give permission to leave messages on my voice mail at work (Test Results or Appointment information). Phone # \_\_\_\_\_

Yes\_\_\_ No\_\_\_ I give permission to release information to my employer or my school regarding absences. Employer \_\_\_\_\_ School \_\_\_\_\_

**Rights of Patient**

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending written notification to the Privacy Officer or Administrator . I understand that revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that the information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand I have the right to refuse to sign this authorization and that my treatment will not be conditional on signing. The Release of Information will remain in effect until terminated by me in writing.

Signature of patient or representative \_\_\_\_\_ Date \_\_\_\_\_

Signature of Shea Clinic representative \_\_\_\_\_ Date \_\_\_\_\_





# SHEA CLINIC

EAR, NOSE AND THROAT

6133 POPLAR PIKE  
MEMPHIS, TN 38119  
PHONE: (901) 761-9720 / FAX: (901) 415-6617

## AUTHORIZATION TO RELEASE MEDICAL INFORMATION

**I AUTHORIZE THE RELEASE OF ALL MY MEDICAL RECORDS INCLUDING ANY APPLICABLE BILLING:**

**FROM:**

\_\_\_\_\_  
Name of Doctor or Hospital

\_\_\_\_\_  
Mailing Address

\_\_\_\_\_  
City/State/Zip

**TO BE FORWARDED TO:**

\_\_\_\_\_  
Name of Doctor

SHEA CLINIC  
6133 Poplar Pike  
Memphis, TN 38119

\_\_\_\_\_  
Patient's Name (Please Print)

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City/State/Zip

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Date of Last Office Visit

\_\_\_\_\_  
Signature of Patient (Parent or Guardian)

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date Signed