

DIRECTIONS TO NIHA

From Baltimore & Maryland

EASIEST

Take I-95 South to I-495 West heading toward Rockville.

From I-495, take Exit 34 and stay in the far right lane which forks and loops south onto Wisconsin Avenue, Route 355.

(Note: North of I-495 Rt. 355 is Rockville Pike, south of I-495 Rt. 355 is Wisconsin Avenue.)

Stay on Wisconsin Avenue for about 4-5 miles, crossing Western Avenue.

The next light is Jenifer Street. Take a left on to Jenifer Street.

Turn right down the first ramp into parking garage (same garage as Red Door Spa)

The elevators for the building are between the parking garage floors, accessible only via steps.

The office is on the 4th floor, Suite #402, turn left after exiting elevator.

FASTEST

Take I-95 South to I-495 West heading toward Rockville

Stay on I-495 until Connecticut Ave. (Exit 33)

Take Connecticut Ave. South toward Washington, DC

Go ½ way around Chevy Chase Circle and continue straight on Connecticut Ave.

Turn Right onto Military Road and continue for approximately ½ mile

Turn Left onto 43rd Street, go to the end of the block where you are forced to turn Right onto Jenifer Street.

Take a Left down the last ramp (before Wisconsin Ave.) into the parking garage (same garage as Red Door Spa)

The elevators for the building are between the parking garage floors, accessible only via steps

The office is on the 4th floor, Suite #402, turn left after exiting elevator

From Virginia

From I-95 take the Capital Beltway (I-495 North) toward Tysons Corner and Maryland

Take I-495 into Maryland, take River Road-East (Exit 39) toward Bethesda, MD & DC

Follow River Road for approximately 6 miles

Turn left at Western Avenue, follow for approximately ½ mile

Turn right onto Jenifer Street at Lord & Taylor

Follow Jenifer Street until it crosses Wisconsin Avenue

Turn right down the first ramp into parking garage (same garage as Red Door Spa)

The elevators for the building are between the parking garage floors, accessible only via steps

The office is on the 4th floor, Suite #402, turn left after exiting elevator

Via Metro

Take Red Line to Friendship Heights Metro Station

Exit the Station via the Jenifer Street Exit-via elevator

Upon leaving Metro Station, 5225 *Wisconsin Avenue* building is across the street

The office is on the 4th floor, Suite #402, turn left after exiting elevator

Handicap Access

The parking garage has handicap parking spaces near the elevators, but to get to the elevators, you must walk up or down 7 steps. If steps are difficult to use, we recommend that you park on the street in front of or behind the building and use those handicap accessible entrances to the building. If you need assistance, please advise us in advance and we will provide support and a wheel chair if needed. We apologize for the inconvenience.

PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

National Integrated Health Associates

5225 Wisconsin Ave., NW, Suite 402

Washington, DC 20015

**FOR YOU:
START HERE**

DATE				1
NAME				
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE NO.				
E-MAIL ADDRESS				
BIRTHDATE	AGE	MALE	FEMALE	
MARRIED	SINGLE	DIVORCED	WIDOWED	
SOCIAL SECURITY NO.				
DATE				
NAME				
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE NO.				
BIRTHDATE	AGE	MALE	FEMALE	
SCHOOL		GRADE		
SOCIAL SECURITY NO.				
IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO				

**FOR YOUR
CHILD:
START HERE**

INSURANCE		2
PRIMARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYEE		
DATE OF BIRTH		
DATE EMPLOYED		
UNION OR LOCAL NO.		
EMPLOYEE NO.		
EMPLOYEE SOCIAL SECURITY NO.		
SECONDARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYEE		
DATE OF BIRTH		
DATE EMPLOYED		
UNION OR LOCAL NO.		
EMPLOYEE NO.		
EMPLOYEE SOCIAL SECURITY NO.		

ACCOUNT INFORMATION		4
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT		
NAME		
RELATIONSHIP TO PATIENT		
ADDRESS		
CITY		STATE ZIP
PHONE NO.		
E-MAIL ADDRESS		
YOU		
NAME		
OCCUPATION		
EMPLOYER		
BUSINESS ADDRESS		CITY
BUSINESS PHONE NO.		EXT.
YOUR SPOUSE		
NAME		
OCCUPATION		
EMPLOYER		
BUSINESS ADDRESS		CITY
BUSINESS PHONE NO.		EXT.

GETTING TO KNOW YOU		3
DID A MEMBER OF YOUR FAMILY OR A FRIEND (WHO IS A NIHA PATIENT) REFER YOU TO THIS OFFICE?		
NAME:		
RELATIONSHIP:		
IF NOT, HOW DID YOU HEAR ABOUT NIHA?		
YOUR FORMER ADDRESS:		
CITY		STATE ZIP
PERSON TO CONTACT FOR EMERGENCY:		
NAME:		
PHONE NUMBER:		
ADDRESS:		
CITY		STATE ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU:		
NAME:		
PHONE NUMBER:		
ADDRESS:		
CITY		STATE ZIP

AUTHORIZATION & ACKNOWLEDGEMENTS
—YEARLY UPDATE

National Integrated Health Associates (NIHA)
5225 Wisconsin Ave. ♦ Suite 402 ♦ Washington DC 20015
Tel: 202-237-7000 ♦ www.NIHAdc.com ♦ Fax: 202-237-0017

Treatment Authorization: I [print name] _____ authorize medical/dental treatment of myself or my minor child by physicians, dentists or medical assistants and staff at National Integrated Health Associates (NIHA).

Notice as to Nature of Services: I understand that care I receive at NIHA may be non-traditional or non-conventional. Such services are commonly referred to as integrative, functional, complementary or alternative or holistic medicine or biological dentistry. Many of these services may not be recognized as standard medical/dental practices, and may be considered to be unproven or supported by inadequate evidence by medical associations or agencies. Medications prescribed may be approved by the FDA for a different condition than that for which it is prescribed for me. I understand my doctor may request laboratory evaluation that may include venipuncture, and analysis of stool, urine and saliva, and that some of these tests, while approved for patient use, may not be considered standard testing or subjected to interpretations based upon functional approaches to medicines.

Notice That Services are Not Primary Care: I understand that the physicians or practitioners I see at NIHA do not act as my primary care physician, except that Tracy Freeman, M.D. may provide limited primary care services as defined by mutual written agreement. I understand that even though my physician(s) and NIHA practitioners may address issues affecting my general health, they do not become responsible for my health generally simply because he/she may conduct a searching and broad investigation to provide a response to my chief complaint(s). NIHA practitioners' practice is focused on a complementary, holistic approach to care and it is in my best interest to also have a primary care physician to ensure that I am fully informed about all available conventional means to address any medical conditions I may have. I should also consider, in selecting who should provide primary care services, their role in hospital services. NIHA is exclusively office-based and none of its practitioners are affiliated with a hospital. If I become so ill that I require hospitalization, it may be in my interest to have a relationship with a physician with hospital admitting privileges familiar with my health problems and history. I understand that in addition to a primary care physician, it may be in my best interest to have appropriate specialists, such as a cardiologist if I have cardiac problems or a pediatrician if I am seeking treatment for my children.

I also understand that it is my responsibility to inform NIHA who my primary care physician and specialists are, to let my physician know of any diagnoses I have received, and of any treatments I have had or am now undergoing for current conditions, and that I should keep my physician and any practitioners I see informed on an ongoing basis. I also understand that it is very important to let my primary care physician know about any treatments performed at NIHA in order to properly and safely coordinate my care. My primary care physician is:

Name _____ Address _____

City/State/Zip _____ Phone _____

I am also being treated for _____ by:

Name _____ Address _____

City/State/Zip _____ Phone _____

Medical/Dental Records Release Authorization: I have executed a HIPAA authorization, and have authorized NIHA to release my medical/dental information to any physician or health practitioner involved in my care and to any payer of my care including my insurance company, managed care program, or Medicare carrier upon their specific request. I also authorize any physician or health care provider I have seen to release my medical/dental records to NIHA.

Financial/Insurance Responsibility for All NIHA Services: I understand and agree to the following policies regarding financial and insurance responsibilities. Payment is required at each visit; NIHA does not accept assignment for medical services. I am responsible for charges incurred for all treatment rendered. This responsibility includes co-payments, deductible amounts, non-covered and excluded items. I agree that I am responsible for any payments for services my insurance carrier determines, either now or at a later date, to be unreasonable or not medically or dentally necessary. I understand that my insurance carrier or other third-party responsible for coverage of my medical/dental expenses may deny coverage because of differences between integrative and conventional medicine, but I choose to receive and will pay for such care. I understand that I am responsible for payment of fees for laboratory or other clinical services ordered by my treatment practitioner(s). NIHA will not be obligated to take action on my behalf against an insurance carrier for collecting or negotiating my insurance claim. I also agree to be responsible for costs and expenses, including court costs, attorney fees and interest, should it be necessary for NIHA to take action to secure payment of an outstanding balance owed.

Notice to Medicare Patients: The doctors at NIHA have opted entirely out of the Medicare program, which means that Medicare will not cover any services or procedures performed at NIHA. I understand that I will not be able to submit any claims to Medicare and that if I have a secondary insurance carrier that carrier may or may not choose to reimburse claims that would have been covered had I seen a physician who accepts payment for Medicare. I understand that I will need to sign a contract (Medicare Private Contract Agreement) agreeing not to submit claims to Medicare, that NIHA will charge me the rates it determines without being limited by Medicare fees, and that I will be financially responsible for any services received. I understand that some services may be considered

by Medicare to be non-covered, excluded, or considered not medically necessary due to their nature as complementary medical practices. I understand that Medicare will not be reviewing any claims, and that an opinion by Medicare that a service is not medically necessary in their view of care does not change my responsibility to pay for services.

Notice about Tricare Insurance: Drs. Charles Gant, Bruce Rind and Barbara Solomon will not accept any new patients nor treat any patients with Tricare Insurance. All other practitioners do accept Tricare patients and insurance for covered services. Patients are responsible for payment in full for non-covered services.

Claim Management: My treating practitioner(s) may respond to insurance requests for information, but will not be obligated to take action on my behalf against an insurance carrier for collecting or negotiating my insurance claim. I understand I may be charged for responding to requests for information. Insurance claim forms and information will be provided to patients at the time of visit or sent to the patient upon the availability of the appropriate documentation. NIHA does not typically send information directly to insurance carriers due to problems it has experienced with carriers losing claims.

NIHA will provide a claim form (CMS 1500) for submission to insurance for licensed practitioners and special services such as IV or laboratory services for claims NIHA believes may be covered; submission shall be the patient's responsibility. NIHA reserves the right in preparing claim submissions to include those procedural codes or other data that accurately reflect services, and to invoice non-covered services using internal descriptions without the use of procedural codes. NIHA will make an effort to provide sufficient information to allow an insurer to determine what services it will reimburse, but is not responsible for any insurance company decision. As NIHA does not participate with medical insurance companies, NIHA reserves the right to determine whether and how it will respond to insurance company requests for records. Patients may always obtain records and provide them in support of their claims. If possible, I understand that NIHA will advise whether my insurance will cover any particular expenses, but given the uncertainty that pervades insurance decisions, cannot be responsible for any information that turns out to be incorrect.

No Guarantees: I am aware that no practice of medicine or dentistry is an exact science, and acknowledge that there are and can be no guarantees as to accuracy or outcomes of any diagnosis or treatments that I receive at NIHA.

Revocation of Authorizations: The authorizations may be revoked by me in writing at any time. Such revocation will not affect my financial responsibility to pay for services rendered.

Patient Acknowledgment: I certify that the information I provide to my practitioners and my insurance company is correct. I certify that I am here to receive medical/dental care and for no other purpose. I do not represent any third party. I agree that I will make no audio/video recordings within NIHA's offices.

Patient Contact/Messages: By my initials, I authorize NIHA staff to leave private or confidential health information messages on my voice mail, or with whomever answers, at the following telephone number(s): ____ Home ____ Cell ____ Work
Further, I authorize protected health information to be sent to this e-mail address: _____

_____/date_____
Signature of Patient or Legal Guardian

_____/date_____
Witness

Annual Update Questions: Address, Telephone, email or Insurance Company Changes? If so, please update the information below.

Review, Initial and Date Annually

Date:_____ New address/phone #/email_____

=====

Date:_____ New address/phone #/email_____

National Integrated Health Associates, LLC (NIHA)
PAYMENT POLICY

Thank you for choosing our office. If you have any questions regarding fees for our services, please discuss them with us promptly and frankly. We will make every effort to avoid misunderstandings and preserve our relationship. In all cases, it is our intent to fully explain and inform you of all procedures, options and fees in advance of treatment. If you ever have questions or feel uninformed, please ask.

Payment is due in full at the time the treatment or service is started. Payment may be made with any combination of the following: cash, checks, MasterCard, Visa, and Discover. For your convenience we are able to arrange an extended payment plan through the use of Care Credit. Please feel free to request an application.

Medical Insurance

Our medical practitioners will provide you with a detailed invoice and a copy of their treatment notes, as needed, when you check-out. For services rendered that may be covered by an insurance plan, when you check-out we will provide you with the standard forms typically needed for filing a claim. Please be advised, however, that some of the services provided may not be covered by most insurance companies. Several practitioners and our Lab do not accept Tricare, while none of our practitioners or Lab accept Medicare. We are sorry, but due to the time and difficulty involved in working with insurance companies we have to limit our involvement. However, for those carriers we do accept, we only file and follow-up insurance claims for our primary care practitioners. For all other practitioners, you will need to file your own medical claim and follow-up as needed.

Dental Insurance

Many of our dentists accept dental insurance plans and will file dental claims on your behalf. Benefit quotes from your insurance company are not a guarantee of payment. You are responsible for payment of all services rendered on your behalf or for your dependents. Payment is due at the time of service unless other arrangements have been made.

Missed Appointment Fee

To avoid incurring a missed appointment fee, a 48-Hour notice is required. Missed or broken appointments can interfere with your treatment plan, waste valuable staff time and raise everyone's fees. Our broken appointment policy is strictly enforced and is intended to prevent ALL patients from having to pay higher fees due to the behavior of a few. A broken appointment fee will range from \$25 to \$200 (up to 50% of the visit's fee).

Finance Fees and Charges

If you pay at the time services are rendered, there are no finance fees. If there is a balance on your account and it has not been fully satisfied within 30 days, you will be charged a monthly billing and interest fee at a rate of 1.5% per month on the outstanding balance. If your bank returns your check (due to insufficient funds or closed account) you will be charged \$25.00. If your account needs to be turned over to a third party for collection, there will be a charge of at least 50% of your total balance to cover attorney's fees and other collection costs.

If you have any questions, PLEASE do not hesitate to ask us. We are here to help you.

I, _____, have read, understand and agree to comply with the above payment policy.
I am providing my Social Security Number, _____, to assist with the payment process.

_____/Date: _____

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Signature of Patient or Legal Guardian Renewal: Initial and Date

_____/Date: _____

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Witness Renewal: Initial and Date

National Integrated Health Associates

Notice to Patients

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

- A. The General Authorization for Release of Medical Records that you sign authorizes your medical care provider, NIHA (“Provider”), to disclose the information in your medical records to the extent needed for the following purposes:
 - 1. For the purpose of providing treatment to you. This would include, for example, sharing information with employees and contractors of Provider, or with other health care providers who are treating you or consulting in your care.
 - 2. For the purpose of arranging payment for your care. This would include, for example, your insurer or other third-party payor who is responsible for paying all or part of the cost of your care.
 - 3. For the purpose of Provider’s “health care operations.” This would include such things as internal quality assessment activities, contacting other health care providers regarding treatment alternatives, evaluating provider performance, training providers of care, legal and medical review of care provided, business planning and management, customer service, resolutions of internal grievances and the provision of legal and auditing services.
 - 4. For the purpose of other health care provider’s “health care operations,” to the extent that they have a treatment relationship with you.
- B. A Specific Authorization for Release of Medical Records that you may sign authorizes Provider to make a specific disclosure that is not covered under section A, above. A Specific Authorization will name the party to whom you are authorizing disclosure, and will contain any limitations on the authority to disclose your records.
- C. You may revoke any authorization provided to Provider by giving Provider a written notice of revocation. Provider may refuse to treat you if you revoke General Authorization.
- D. Provider may be required by law, in some cases, to make disclosures of your record that you have not authorized. Examples are subpoenas in criminal or civil litigation, or requests/surveys by licensure agencies or the U.S. Department of Health and Human Services.
- E. Provider may contact you to provide appointment reminders or information about treatment alternatives or health-related benefits and services that may be of interest to you.

- F. You have the following right with respect to your medical records/information:
 - 1. You have the right to request restrictions on the use and disclosure of your medical records/information, however Provider is not required to agree to restrictions not guaranteed by law. You will be informed if Provider will not agree to a requested restriction.
 - 2. You will have the right to receive confidential communications of your health information and to direct the place and manner of communication.
 - 3. You have the right to inspect and copy your medical records. (Provider is entitled to charge you a reasonable fee related to the cost of copying your records).
 - 4. You have the right to seek to amend your medical records, and if Provider does not agree with your request, to note your objection in the medical record.
 - 5. You have a right to receive an accounting (list) of disclosures of your medical records/information made by Provider. (Except for those disclosures that are made to you or with your specific authorization, that fall within the scope of Provider's "health care operations," or disclosures made for payment or treatment purposes.)
 - 6. You have the right to receive a paper copy of this notice.
- G. Provider is required by law to maintain the privacy of protected health information, and to provide patients with this notice of its duties and practices, as well as changes to those practices. Patients will be provided with revised notices, as appropriate.
- H. If a patient believes that his or her privacy rights have been violated, the patient may complain to Provider, or to the Secretary of the U.S. Department of Health and Human Services. To complain to Provider, please write or call us with the details. Provider will not retaliate in any way against a patient for making a complaint.
- I. If you as a patient or guardian believe that your privacy rights have been violated, and wish to notify our practice, please call our office and ask to speak with our designated Privacy Complaints Contact Person: Contact Person Name**.
- J. Provider reserves the right to change its privacy practices and to make its new policies effective for all protected health information that provider maintains. If such changes are made, Provider will issue an updated "Notice to Patients" to all of Provider's patients.

Please acknowledge receipt and review of this notice by signing below. For further information please call 202-237-7000.

Name of Patient (printed)

Date

Signature of Patient or Lawfully Authorized Representative
Effective Date _____, 20__

**National Integrated Health Associates
Dental History**

Patient Name: _____ Date: _____

What is the reason for today's visit? _____

Date of last dental visit _____ Reason _____

Date of last cleaning _____ Date of last X-rays _____

Previous dentist's name _____

Address _____

City / State / ZIP _____

How often do you have dental check-ups? _____

How often do you brush? _____ floss? _____

What dental aids do you use? _____

What dental problems do you have now? _____

Are any of your teeth sensitive to: (please circle)

Hot or cold? Yes No

Sweets? Yes No

Biting or chewing? Yes No

Do you get cold sores or other oral lesions? Yes No

Do you notice mouth odors or bad tastes? Yes No

Do your gums bleed or hurt? Yes No

Do you notice any loose teeth or change in your bite? Yes No

Does food tend to get caught in your teeth? Yes No

Do you smoke or chew tobacco? Yes No

Do you clench or grind while awake or asleep? Yes No

Do you mouth breathe while awake or asleep? Yes No

Have you noticed clicking or popping of the jaw? Yes No

Do you have difficulty opening or closing? Yes No

Do you have pain or difficulty chewing? Yes No

Do you have tired jaws, especially in the morning? Yes No

Are you satisfied with the appearance of your teeth? Yes No

Rate your smile (on a scale of one to ten) _____

Would you like to keep all of your teeth for life? Yes No

Have you ever had:

Orthodontic treatment? Yes No

Oral Surgery? Yes No

Periodontal Treatment? Yes No

A bite plate or mouth guard? Yes No

A serious injury to the mouth or head? Yes No

Your teeth ground or bite adjusted? Yes No

Pain in jaw, joint, ear or side of face? Yes No

Do you feel nervous about today's appointment? _____

What is your biggest concern? _____

What did you like best at your last dental office? _____

What did you like least? _____

Have you ever had an upsetting dental experience? Yes No

If so, what was it? _____

Is there anything else we should know? Yes No

Please rank the following in the order in which they would

KEEP YOU from having treatment:

Fear of pain ____ Cost of treatment ____ Lack of concern ____

Missing time from work __ Embarrassed by dental condition ____

MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years?..... Yes No
If yes, for what? _____
Physician's Name _____ Phone _____
Address _____
City/State/Zip _____
2. Have you taken any medication or drugs during the past two years?..... Yes No
3. Are you taking any medication, drugs or pills now?..... Yes No
If yes, please list name and dosage _____
4. Are you aware of having an allergic (or adverse reaction) to any medication or substance? Yes No
If yes, please list: _____
5. Have you been a patient in the hospital during the past five years?..... Yes No
6. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.
- | | | | | | |
|----------------------------------------|--------|-------------------------|--------|-----------------------------------------|--------|
| Heart (Surgery, Disease, Attack)..... | Yes No | Ulcers..... | Yes No | Hepatitis A (infectious) B (serum)..... | Yes No |
| Chest Pain..... | Yes No | Diabetes..... | Yes No | Venereal Disease..... | Yes No |
| Congenital Heart Disease..... | Yes No | Thyroid Problems..... | Yes No | A.I.D.S..... | Yes No |
| Heart Murmur..... | Yes No | Glaucoma..... | Yes No | H.I.V. Positive..... | Yes No |
| High Blood Pressure..... | Yes No | Contact Lenses..... | Yes No | Cold Sores/Fever Blisters..... | Yes No |
| Mitral Valve Prolapse..... | Yes No | Emphysema..... | Yes No | Blood Transfusion..... | Yes No |
| Artificial Heart Valve..... | Yes No | Chronic Cough..... | Yes No | Hemophilia..... | Yes No |
| Heart Pacemaker..... | Yes No | Tuberculosis..... | Yes No | Sickle Cell Disease..... | Yes No |
| Rheumatic Fever..... | Yes No | Asthma..... | Yes No | Bruise Easily..... | Yes No |
| Arthritis/Rheumatism..... | Yes No | Hay Fever..... | Yes No | Liver Disease..... | Yes No |
| Cortisone Medicine..... | Yes No | Latex Sensitivity..... | Yes No | Yellow Jaundice..... | Yes No |
| Swollen Ankles..... | Yes No | Allergies or Hives..... | Yes No | Neurological Disorders..... | Yes No |
| Stroke..... | Yes No | Sinus Trouble..... | Yes No | Epilepsy or Seizures..... | Yes No |
| Diet (Special/Restricted)..... | Yes No | Radiation Therapy..... | Yes No | Fainting or Dizzy Spells..... | Yes No |
| Artificial Joints (hip,knee,etc.)..... | Yes No | Chemotherapy..... | Yes No | Nervous/Anxious..... | Yes No |
| Kidney Trouble..... | Yes No | Tumors..... | Yes No | Psychiatric/Psychological Care.... | Yes No |
| Osteoporosis..... | Yes No | Osteopenia..... | Yes No | | |

Sleep and Snoring Disorders:

- a. Do you use CPAP machine?..... Yes No
- b. Do you experience episodes of frequent, heavy snoring?..... Yes No
- c. Do you experience episodes of GASPING when you are awaking from sleep?..... Yes No
- d. Have you been told that you "stop breathing when you are asleep"?..... Yes No
7. Do you use more than two pillows to sleep?..... Yes No
8. Have you lost or gained more than 10 pounds in the past year?..... Yes No
9. Do you have or have you had disease, condition, or problem not listed?..... Yes No
If yes, please list: _____

10. **Women.** Are you: **Pregnant?** Yes, ____ months No **Nursing?** Yes No **Taking birth control pills?** Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health medication.

Patient/Guardian Signature _____ Date _____

Medical History Review

Staff Member: _____

Date: _____