The Toledo Clinic | ENT

WELCOME TO THE OFFICE OF TOLEDO CLINIC ENT!

Below is important information for your upcoming appointment:

- Please complete the corresponding paperwork and bring all completed paperwork with you the day of your appointment.
- Please contact your insurance company to ensure our providers are in network under your current plan. If your insurance company requires a referral, please have your referring provider submit your referral prior to your appointment.
- Please arrive 15 minutes prior to your appointment to register. If for any reason you are unable to attend your scheduled appointment, please call our office to cancel/reschedule within 24 hours of your appointment. A fee of $50.00 will be charged for appointments not attended or cancelled/rescheduled without a 24 hour notice given.
- Please bring your insurance card, photo ID, and co-payment at the time of your visit.
- All patients are financially responsible for any services rendered regardless of health insurance coverage.
- Our office hours are Monday-Friday, 8:00 AM-4:30 PM.

We look forward to meeting you!

The staff at Toledo Clinic ENT

5800 Park Center Ct., Suite C, Toledo, OH 43615
(419) 724-8368 • www.ToledoClinicENT.com • www.ToledoRhinoplasty.com

The Toledo Clinic | ENT

Adult History and Physical

Please Fill Out Both Sides of Form

Patient Name _____ Sex ☐ M ☐ F DOB _____ / _____ / _____
First MI Last DD YYYY

Primary Care Physician _____ Age _____

Pharmacy _____ Pharmacy Phone # _____

Reason for Referral _____ Onset of Symptoms _____

TO BE COMPLETED BY PATIENT

Do you have a history of any of the following?

METABOLIC/CIRCULATORY

☐ Diabetes ☐ Bleeding Tendencies ☐ High Blood Pressure ☐ Thyroid Disorder
☐ Heart Disease/Attack ☐ Rheumatic Fever

RESPIRATORY

☐ Pneumonia ☐ Asthma ☐ Bronchitis ☐ Lung Problems

NEUROLOGIC

☐ Migraines ☐ Headaches ☐ Seizures/Convulsion

DIGESTIVE

☐ Acid Reflux/GERD ☐ Other _____

IMMUNE

☐ HIV/AIDS/STD ☐ Seasonal Allergies ☐ Food Allergies ☐ Animal Allergies
☐ Eczema ☐ Arthritis ☐ Yeast/Fungal Infection ☐ Allergies to IV Contrast

CANCER

Type: _____ ☐ Chemotherapy ☐ Radiation Therapy Location _____

EAR, NOSE & THROAT

☐ Strep Throat ☐ Tonsillitis ☐ Sinus Problems ☐ Snoring
☐ Ear Infections ☐ Hearing Loss ☐ Ringing in Ears/Tinnitus ☐ Dizziness

Please describe any other problems we need to be aware of: _____

_____

_____

Do you have allergies to any medications? Please list: _____

_____

_____

Exposure to Tobacco ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No Packs per day _____ Years quit? _____ Do you drink? ☐ Yes ☐ No Drinks per day _____

Do you chew? ☐ Yes ☐ No

Do you use snuff? ☐ Yes ☐ No

Are your immunizations up to date? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Current Medications & Supplements: _____

_____

_____

_____

SURGICAL HISTORY

Type of Surgery	*Year of Surgery*	*Right/Left*

Have you had any complications to any surgeries? (please describe)

_____

_____

FAMILY HISTORY

Mother	☐ Alive	☐ Deceased		
Father	☐ Alive	☐ Deceased		
Asthma	☐ Father	☐ Mother	☐ Brother	☐ Sister
Bleeding Tendencies	☐ Father	☐ Mother	☐ Brother	☐ Sister
Cancer	☐ Father	☐ Mother	☐ Brother	☐ Sister
Diabetes	☐ Father	☐ Mother	☐ Brother	☐ Sister
Ear Infections	☐ Father	☐ Mother	☐ Brother	☐ Sister
Ear Surgeries	☐ Father	☐ Mother	☐ Brother	☐ Sister
Food Allergies	☐ Father	☐ Mother	☐ Brother	☐ Sister
Early Hearing Loss	☐ Father	☐ Mother	☐ Brother	☐ Sister
Heart Disease	☐ Father	☐ Mother	☐ Brother	☐ Sister
High Blood Pressure	☐ Father	☐ Mother	☐ Brother	☐ Sister
Seasonal Allergies/Hay Fever	☐ Father	☐ Mother	☐ Brother	☐ Sister
Stroke	☐ Father	☐ Mother	☐ Brother	☐ Sister

The Toledo Clinic | ENT

CONSENT FOR MEDICAL CARE

I, with my signature, authorize the physician, nurse practitioner, physician assistant or audiologist of Toledo Clinic ENT, and any employee working under the direction of the physician, to provide medical care for me or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but is not limited to) preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body, and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

By signing below, I confirm that I have read, or have had read to me, and understand the above information. I am of sound mind, under no undue influence and am competent to make this decision and do so of my own free will.

Signature of Patient/Authorized Representative	Relationship
Patient Name	Date

The Toledo Clinic | ENT

PATIENT/ACCOUNT INFORMATION
THE TOLEDO CLINIC
USE BLACK INK ONLY

DATE _____ ACCOUNT NUMBER _____

DOCTOR _____ PRIMARY CARE PHYSICIAN & CITY _____

A. PATIENT INFORMATION

NAME: LAST	FIRST	INITIAL	___/___/____ DATE OF BIRTH	AGE	☐ M ☐ F SEX	____-____-____ SOCIAL SECURITY

MAIDEN/PREVIOUS	ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE	CELLULAR PHONE	E-MAIL ADDRESS	MARITAL STATUS	SPOUSE NAME

EMERGENCY CONTACT	RELATIONSHIP	PHONE	EXT	CELLULAR PHONE

ADDITIONAL CONTACT	RELATIONSHIP	PHONE	EXT	CELLULAR PHONE

PREFERRED METHOD OF CONTACT
- ☐ CELLPHONE
- ☐ HOME PHONE
- ☐ E-MAIL
- ☐ TEXT

RACE
- ☐ AMERICAN INDIAN OR ALASKA NATIVE
- ☐ ASIAN
- ☐ BLACK OR AFRICAN AMERICAN
- ☐ HAWAIIAN OR PACIFIC ISLANDER
- ☐ WHITE
- ☐ OTHER
- ☐ UNKNOWN
- ☐ DECLINED

ETHNICITY
- ☐ HISPANIC OR LATINO
- ☐ NOT HISPANIC OR LATINO
- ☐ UNKNOWN
- ☐ DECLINED
- ☐ JAPANESE
- ☐ SPANISH
- ☐ VIETNAMESE
- ☐ UNKNOWN

LANGUAGE
- ☐ ARABIC
- ☐ CHINESE
- ☐ ENGLISH
- ☐ FRENCH

B. PERSON RESPONSIBLE FOR PAYMENT- IF PATIENT IS A CHILD, THE PERSON WHO HAS CUSTODY

NAME: LAST | FIRST | INITIAL | ___/___/____ DATE OF BIRTH | ___ AGE | ☐ M ☐ F SEX | ____-_____-_____ SOCIAL SECURITY

MAIDEN/PREVIOUS | ADDRESS | CITY | STATE | ZIP CODE

HOME PHONE | CELLULAR PHONE | E-MAIL ADDRESS | MARITAL STATUS | SPOUSE NAME

C. INSURANCE INFORMATION

INSURANCE COMPANY | POLICY NUMBER | GROUP NUMBER

MAIDEN/PREVIOUS | ADDRESS | CITY | STATE | ZIP CODE

NAME OF POLICY HOLDER | DOB OF POLICY HOLDER | EFFECTIVE DATE | RELATIONSHIP TO PATIENT

INSURANCE EMPLOYER NAME | PCP CO-PAYMENT AMT | SPECIALIST CO-PAY AMT

INSURANCE COMPANY | POLICY NUMBER | GROUP NUMBER

ADDRESS | CITY | STATE | ZIP CODE

NAME OF POLICY HOLDER | DOB OF POLICY HOLDER | EFFECTIVE DATE | RELATIONSHIP TO PATIENT

INSURANCE EMPLOYER NAME | PCP CO-PAYMENT AMT | SPECIALIST CO-PAY AMT

I CONFIRM THAT THE ABOVE INFORMATION IS CORRECT

SIGNATURE | DATE

The Toledo Clinic | ENT

STAFF USE ONLY
Follow Up:_____Kit #:_____
Chart #:_____

Patient Name _____ DOB _____

Date _____ Weight _____ Height _____

THE EPWORTH SLEEPINESS SCALE (ESS)

How likely are you to doze off or fall asleep in the following situations:

0 =**No** chance
1=**Slight** chance
2=**Moderate** chance
3=**High** chance

Score:
0-10 = Normal Range
10-12 Borderline
12-24 Abnormal

Sitting quietly reading a book or magazine	
Watching TV	
Sitting in a public place (eg., movie theatre or meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car while stopped for a few minutes in traffic	
TOTAL	

SYMPTOMS/COMPLAINTS: Have you experienced any of the following? Please check all that apply.

- ☐ Loud Snoring/Snoring
- ☐ Witnessed Apnea
- ☐ Excessive Sleepiness
- ☐ Wake Up Choking
- ☐ Confusion
- ☐ COPD
- ☐ High Blood Pressure
- ☐ Mood Swings
- ☐ AFIB
- ☐ Weight Gain
- ☐ Depression
- ☐ Smoking
- ☐ Awakens with Headache
- ☐ Legs Twitching/Jerking
- ☐ Forgetfulness
- ☐ Awakens Gasping for Air
- ☐ Insomnia
- ☐ TIA/History of Stroke

PATIENT RESPONSIBILITY: I agree to return the sleep recorder, including the finger sensor, belt and tape to Toledo Clinic ENT in the same condition as it was dispensed to me for my sleep test. I also agree to return the sleep recording system by _____ or I will be financially responsible for its replacement.

Patient Signature _____ Date _____

Date returned _____ Patient signature _____ *Staff initials* _____

The Toledo Clinic | ENT

Toledo Clinic Inc.'s Notice of Privacy Practices for Protected Health Information

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.

I. Uses and Disclosures of Your Medical Information.

A. Treatment, Payment and Operations. Toledo Clinic Inc. (sometimes referred to as "we" or "us") is permitted to use your medical information for purposes of treating you, to obtain payment for providing medical services to you and to assist in its health care operations. We may also use your medical records to assess the appropriateness and quality of care that you received, improve the quality of health care and achieve better patient outcomes. An understanding of what is in your health records and how your health information is used helps you ensure its accuracy and completeness; understand who, what, where, why and how others may access your health information; and make informed decisions about authorizing disclosures to others.

(i) Use of Your Protected Health Information for Treatment Purposes. A physician or another member of your health care team will record information in your record to diagnose your condition and determine the best course of treatment for you. We will also provide your primary physician, other health care professionals or a subsequent health care provider with copies of your records to assist them in treating you.

(ii) Use and Disclosure of Your Protected Health Information for Purposes of Payment. We may send a bill to you or to a third-party payer, such as a health insurer. The information on or accompanying the bill may include information that identifies you, your diagnosis, treatment received and supplies used.

(iii) Use and Disclosure of Your Protected Health Information for Health Care Operations. Health care operations consist of activities that are necessary to carry out our operations as a health care provider, such as quality assessment and improvement activities. For example, members of our medical staff, the risk or quality improvement manager or members of the quality assurance team may use information in your health record to assess the care and outcomes in your cases and the competence of the caregivers. We will use this information in an effort to continually improve the quality and effectiveness of the health care and services that we provide.

B. Appointment Reminders. We may contact you at home to provide appointment reminders unless you specify otherwise in writing to us.

C. Other Purposes for Which We Can Use Your Protected Health Information Without Written Authorization From You. In addition to

Toledo Clinic Inc.'s Notice of Privacy Practices for Protected Health Information using your protected health information for purposes of treatment, payment and health care operations, we may use or disclose your protected health information without your written authorization and without giving you an opportunity to object in the following situations:

(i) As Required by Law. We may use or disclose your protected health information as required by law. We will limit the disclosure to those portions relevant to the requirements of the law.

(ii) Public Health Activities. We may use or disclose your protected health information to public health entities authorized to collect information for the purposes of controlling or preventing disease (including sexually transmitted diseases), injury or disability. We may also disclose to governmental agencies authorized to receive reports of child abuse or neglect. We may disclose protected health information to the Food and Drug Administration relative to adverse effects and events with respect to food, drugs, supplements, product or product defects or post-marketing surveillance information to enable product recalls, repairs or replacement.

(iii) Medical Surveillance of the Workplace and Work-related Injuries. We may provide your protected health information to your employer if we are asked by your employer to provide medical services to you for purposes of medical surveillance of the workplace or a work- related illness or injury.

(iv) Victims of Abuse, Neglect or Domestic Violence. To the extent authorized or required by law, and in the exercise of our doctor's professional judgment, if we believe the disclosure is necessary to prevent harm, we may disclose protected health information to law enforcement officials.

(v) Health Oversight Activities. We may disclose your protected health information to a governmental health oversight agency overseeing the health care system, governmental benefit programs or compliance with governmental program standards.

(vi) Judicial and Administrative Proceedings. We may disclose your protected health information in response to an order of a court or a valid subpoena.

(vii) Law Enforcement Purposes. We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena, or we may provide limited information for identification or location purposes.

(viii) Information About Deceased Individuals. We may disclose your protected health information to coroners and medical examiners to carry out their official duties and to funeral directors as necessary to carry out their duties to the deceased individual.

(ix) Organ, Eye or Tissue Donation. We may disclose protected health information to organ procurement agencies for the purpose of facilitating organ, eye or tissue donation or transplantation.

(x) Research Purposes. We may disclose protected health 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 protected health information.

(xi) Avoidance of Serious Threat to Health or Safety. We may disclose protected health information if we believe in good faith that such disclosure is necessary to prevent or lessen a serious and immediate threat to health and safety of a person or the public.

(xii) Certain Specialized Governmental Functions. If you are Armed Forces or foreign military personnel, we may disclose your protected health information to your appropriate military command. We may disclose your protected health information to a governmental agency as authorized by the National Security Act or for the protection of the President of the United States, as required by law.

(xiii) Correctional Institutions. If you are an inmate, we may disclose your protected health information to the correctional institution or law enforcement in the course of providing care to you or the health and safety of others responsible for your custody or other inmates.

(xiv) Disclosures for 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.

D. Other Uses and Disclosures of Your Protected Health Information Will Only Be Made With Your Prior Written Authorization. This includes, but is not limited to: (i) uses and disclosures of psychotherapy notes (if applicable); (ii) certain uses and disclosures for marketing purposes, including direct or indirect remuneration to Toledo Clinic; (iii) uses and disclosures that constitute a sale of your protected health information; and (iv) other uses and disclosures not described herein. You may revoke an authorization at any time, provided you do so in writing. We will honor such a revocation except to the extent that we had already taken action in reliance upon your prior authorization.

II. Your Individual Rights. You have the following rights under federal law with respect to your protected health information and may exercise them in the following manner:

A. The Right to Request Restrictions on the Use of Protected Health Information. You have the right to request that we restrict the use of your protected health information. You have the right to request that we limit our disclosure of your protected health information to treatment, payment, and health care operations and disclosures to individuals (family members) involved in your care. Such a restriction, if agreed to by us, will not prevent permitted or required uses and disclosures of protected health information. We are not required to agree to any requested restriction. You also have the right to restrict certain disclosures to a health plan if and when you pay out of pocket and in full for the health care item or service.

B. The Right to Receive Confidential Communications of Protected Health Information by Alternative Means. We must accommodate a reasonable written request by you to receive communications of your protected health information by alternative means (e.g., via email) or at an alternative location (e.g., at your place of employment rather than at home).

C. The Right to Inspect and Copy Your Medical Records. You have the right to inspect and obtain a copy from us of your protected health information in our possession, including an electronic copy of your protected health information that we maintain electronically in a designated record. We may impose a reasonable cost-based fee for the labor involved and supplies used for creating the copy of your medical records.

D. The Right to Amend Protected Health Information. You have the right to have us amend protected health information in our possession. You must make the request in writing and provide supporting reason(s) for the requested amendment. If we grant the request, we will notify you, and we will make the correction and distribute the correction to those who need it and those whom you identify to us that you want to receive the corrected information.

E. The Right to Receive an Accounting of Disclosures of Protected Health Information. You have the right to obtain an accounting of disclosures by us of your protected health information, other than for purposes of treatment, payment and health care operations. Depending on whether your particular doctor has incorporated electronic health records into his or her medical practice, you may have the right to obtain an accounting of all disclosures of protected health information. The first accounting in any 12-month period is free. Thereafter, we reserve the right to charge a reasonable, cost-based fee.

F. The Right to Obtain a Paper Copy of This Notice Upon Request. You have the right to receive a paper copy of this Notice upon request.

G. The Right to Opt Out of Fundraising Communications. In the event we choose to contact you for purposes of fundraising, you will be given the opportunity to opt out of such fundraising communications.

H. The Right to Opt Out of Health Information Data Exchanges. The Toledo Clinic endorses, supports and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of care and health care experience. The HIE provides us with a way to securely and efficiently share clinical information electronically with other physicians and health care providers that participate in the HIE network. Making your health care information available to other providers can also help reduce your costs by eliminating unnecessary duplication of tests. Your electronic health information will be used by Heath Information Exchange participants in order to: provide you with medical treatment and related services; evaluate and improve the quality of medical care provided to all patients. Unless you opt out of this data exchange, The Toledo Clinic will share your electronic health information with other health information exchange participants that are involved with your care. This information includes, but is not limited to, information about your diagnosis, test results and medications. Opting out does not prevent your provider from direct sharing of your health information from a direct provider to provider exchange. It also does not prevent the notification of your primary care provider from information related to services you have received in other facilities. Please be aware that federal law protects your health information from being improperly disclosed and you are able to opt out at any time.

III. Our Duties to Safeguard Your Protected Health Information.

A. Our Duties to You. We are required by federal law to maintain the privacy of protected health information and to provide you with notice of its legal duties and privacy practices with respect to your protected health information. We will maintain the privacy of your health information, including implementing reasonable and appropriate physical, administrative and technical safeguards to protect the information. We have the duty to mitigate any breach of privacy regarding your protected health information. In the event of any breach of privacy regarding your protected health information, the Toledo Clinic is required to notify you.

B. Privacy Notice. The Toledo Clinic is required to abide by the terms of its Privacy Notice as currently in effect.

C. Complaints. You may complain to us or the Secretary of Department of Health and Human Services if you believe your privacy rights have been violated. You may file a Patient Privacy Complaint with our Privacy Officer. You will not be retaliated against for filing a complaint. To report a complaint or concern

Via Phone: 844-481-4941

Online: Toledoclinic.Ethicspoint.com

D. Contact Person and Telephone Number. If you have questions or would like additional information, you may contact Toledo Clinic's Privacy Officer at 419-479-5996.

E. Effective Date. This Privacy Notice is Effective March 31, 2013. Revised March, 19, 2019.

WE RESERVE THE RIGHT TO CHANGE THE TERMS OF OUR NOTICE OF PRIVACY PRACTICES AND TO MAKE THE NEW NOTICE PROVISIONS EFFECTIVE FOR ALL PROTECTED HEALTH INFORMATION THAT WE MAINTAIN. IF WE CHANGE OUR INFORMATION PRACTICES, WE WILL POST THE REVISED NOTICE IN THE OFFICE AND PROVIDE YOU WITH A COPY UPON REQUEST.

The Toledo Clinic | ENT

ACKNOWLEDGMENT OF RECEIPT OF TOLEDO CLINIC'S NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that I have received Toledo Clinic's Notice of Privacy Practices effective April 14, 2003, rev 03/31/2013.

_____

Signature of Patient

_____

Printed Name of Patient Date of Birth

_____

Signature of Parent/Guardian of Minor

_____

Date

STAFF USE ONLY

Good Faith Effort to Obtain Acknowledgment

The above named patient refused to sign the acknowledgment after being requested to do so.

_____

Staff Member Signature

Date: _____

PERSONS THAT ARE ALLOWED TO GIVE AND RECEIVE MY PRIVATE HEALTH INFORMATION

METHOD OF ALLOWED RELEASE: _____ VERBAL _____ WRITTEN

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

Financial Policy

We are committed to providing our patients with the best possible medical care and minimizing administrative costs. This financial policy has been established with these objectives in mind and to avoid any misunderstanding or disagreement concerning payment for professional services.

- Our practice participates with numerous insurance companies. For patients who are beneficiaries of one of these insurance companies, our billing office will submit a claim for services rendered. All necessary insurance information, including special forms, must be completed by the patient prior to leaving the office.
- If a patient has insurance in which we do not participate, we are happy to file the claim upon request; however, payment in full is expected at the time of service.
- It is the patient's responsibility to pay any deductible, copayment or any portion of the charges as specified by the plan at the time of visit. Payments for medical services not covered by an individual's insurance plan are the patient's responsibility, and payment in full is due at the time of visit.
- Payment for professional services can be made with cash, check or credit card.
- Patients who do not have insurance are expected to pay for professional services at the time of service.
- It is the patient's responsibility to ensure that any required referrals for treatment are provided to the practice prior to the visit. Visits may be rescheduled or the patient may be financially responsible due to lack of the referral.
- It is the patient's responsibility to provide us with current insurance information and to bring their insurance card to each visit. If claims are rejected by insurance company due to untimely filing limits, and the delay is a result of the patient not providing insurance information timely, the patient will be responsible for all charges.
- Our staff is happy to help with insurance questions relating to how a claim was filed, or regarding any additional information the payer might need to process the claim. Some specific coverage issues can only be addressed by the insurance company member services department. The telephone number is printed on the insurance card.
- The adult accompanying a minor and the parents (or guardians of the minor) are responsible for payment at the time of service. For unaccompanied minors, non-emergent treatment will be denied unless charges have been pre-authorized or payment by credit card, cash, or check at the time of service has been verified. Statements indicating any patient responsible balance will be mailed monthly. Payment in full is due within 30 days.
- Patient balances over 30 days will be subject to a late payment charge equal to 1.25% (15% annual percentage rate) of the balance as of the end of each month.
- Patients will be asked to pay all patient responsible balances in full when they are seen in the office at their next visit.
- Patients with outstanding balances may not be seen by the physician absent medical necessity and are subject to discharge from the practice.
- In the unanticipated event you are unable to pay your bill when due, please contact us as informal arrangements may be worked out.
- Any prepayments resulting in a credit balance to an account will first be applied to any outstanding debt prior to being refunded.

The Toledo Clinic | ENT

Our practice firmly believes that a good physician-patient relationship is based upon understanding and good communications. Questions about financial arrangements should be directed to the Business Services department at 419-479-5398. We are happy to help you.

I hereby authorize The Toledo Clinic to submit to my insurance plan all covered services rendered by the physician(s) and to furnish complete information (including Medical Records, if necessary) to my plan regarding services rendered. I understand that in signing this form, The Clinic will not release to anyone, including those processing my Clinic claim, any information that the law specifically protects and for which a special consent is required. For those records to be released, I will need to sign a separate consent.

I authorize and direct my insurance carrier to issue payment check(s) directly to the physician(s) rendering covered services unless otherwise notified.

AUTHORIZED SIGNATURE

I have read this form or had it read to me. I understand it.

_____ _____

Signature of Patient/Authorized Representative | Relationship (if other than patient)

Patient Name _____ Date _____

Chart # _____

TC-094 Rev 03/19