KENNETH J. GALANG, M.D., P.A.

Patient Biographical Form

First Name | Middle Initial | Last Name | Social Security #

Date of Birth | Age | Male Female (Circle Gender) | Marital Status

Local Address | City

State | Zip Code | Student/Employer | Work Status

Home Phone | Work Phone | E-Mail Address | Race (Optional)

Emergency Contact | Emergency Phone # | Date First Visit | Cell Phone #

Are you a year round resident? YES NO

Northern Address | City | State/Zip

Responsible Party (If patient is Responsible Party please put SAME)

Insured First Name/Subscriber Name | Insured M.I. | Insured Last Name | Subscriber D.O.B.

Address | City | State/Zip

Relationship to Patient | Phone Number

Insurance Information

PRIMARY Insurance Company | Plan Name

Member ID#: _____ Plan #: _____ Group #: _____

Address: _____ City: _____ State/Zip: _____

Phone #: _____ Employer: _____

Coverage Start Date: _____ Coverage End Date: _____

Medigap Payer ID: _____ Co-Pay: _____

SECONDARY Insurance Company | Plan Name

Member ID#: _____ Plan#: _____ Group#: _____

Address: _____ City: _____ State/Zip: _____

Phone #: _____ Employer: _____

Coverage Start Date: _____ Coverage End Date: _____

KENNETH J. GALANG, M.D., P.A.

First Name _____ Middle Initial _____ Last Name _____

PAYMENT INFORMATION

How will you be paying for today's visit? ___Cash ___Check ___Charge ___Other

Is this a work-related injury? YES NO **Date of injury: _____**

Is this an auto accident? YES NO **Date of accident: _____**

Is an attorney involved? YES NO **Name: _____**

Address: _____

_____

Phone: _____

REFERRAL INFORMATION

Whom may we thank for referring you to our clinic?

____ **My Family Physician** _____

____ **Another Patient** _____

____ **Yellow Pages**

____ **Other** _____

I hereby authorize and consent to treatment by **Kenneth J. Galang, M.D., P.A.** as deemed reasonable and necessary by the physician at the time of my visit.

_____ _____

Signature of the Patient/Guardian **Date**

I, _____, hereby assign all medical and/or surgical benefits and rights to which I am entitled to **Kenneth J. Galang, M.D., P.A.** A photocopy or fax of this assignment is as valid as the original.

_____ _____

Signature of the Patient/Guardian **Date**

NAME: _____ DATE: _____
(LAST) (FIRST) (MI)
ADDRESS: _____ DOB: _____

MEDICAL HISTORY QUESTIONNAIRE

1) **Chief Complaint & HPI:** (Chief complaint for which you are seeing the physician today)

_____

_____

_____

Employment Related? YES NO **Auto Accident? YES NO** **Other Accident? YES NO**

Onset of pain: _____
_____
_____

Duration:
___ Constant
___ Intermittent
___ Daily
___ Day and night
___ Other
_____
_____

Quality:
___ Aching
___ Stabbing
___ Throbbing
___ Drilling
___ Burning
___ Builds up slowly
___ Builds up quickly

Location: _____
_____
_____

Intensity: ___ (0-10, 10 is worse pain ever)
_____

When is it worse?
___ With movement
___ Walking
___ Coughing
___ Sitting
___ Lying down
___ Night time
_____

Response to Treatment:

Therapy	worse	better
Medication	worse	better
Injections	worse	better
_____	worse	better

Associated symptoms:
___ Weakness
___ Tingling
___ Numbness
___ _____

2) **Current Medical History:** (Mark "**YES**" or "**NO**", if "**YES**" then describe problem)

Cardiovascular Problems	YES	NO	_____
Pulmonary Problems	YES	NO	_____
Gastrointestinal Problems	YES	NO	_____
Neurological Problems	YES	NO	_____
Blood related Problems	YES	NO	_____
Diabetes or Thyroid Problems	YES	NO	_____
Mental Disorder	YES	NO	_____
Musculoskeletal Problems	YES	NO	_____

3) **Preventive/Past History Screening:** (Mark "Yes" or "No" if you have had any of these conditions)

Polio	YES	NO	Mumps	YES	NO
AIDS/HIV	YES	NO	STD	YES	NO
Blood Transfusion	YES	NO	Hepatitis	YES	NO
Cancer	YES	NO	Depression	YES	NO
Chicken Pox	YES	NO	Arthritis	YES	NO
Epilepsy/Seizures	YES	NO	Skin Disease	YES	NO
Infectious Mono	YES	NO	Heart Problems	YES	NO

NAME: _____ DOB: _____

4) **Past Illness Screening:** (Other medical problems that you take medication for, ex: diabetes)

_____ _____
_____ _____
_____ _____
_____ _____

5) **Past Surgical History:** (List major surgeries have you had)

_____ _____
_____ _____
_____ _____

6) **Current Medication:** (List the prescription and non-prescription medication you take)

Name of Medicine	Dose	Frequency

7) **Drug/Food Allergies:** (List any medication or food allergies you have)

Name of Drug	Type of Reaction

8) **Family Medical/Social History:** (List the medical conditions that run in your family)

			(If "YES" list relationship to you, ex: mother)
Arthritis	YES	NO	_____
Auto Immune Disease	YES	NO	_____
Bleeding Disorder	YES	NO	_____
Blood Pressure	YES	NO	_____
Cancer	YES	NO	_____
Diabetes	YES	NO	_____
Heart Disease	YES	NO	_____
High Cholesterol	YES	NO	_____
Osteoporosis	YES	NO	_____
Other	YES	NO	_____

NAME: _____ DOB: _____

9) **Review of Systems (ROS):** Please mark each item "YES" or "NO" as they relate to your current health

GENERAL	YES	NO
Change in appetite	___	___
Change in weight	___	___
Chills, fever, sweats	___	___

EYES	YES	NO
Glasses/Contacts	___	___
Change in vision	___	___
Double vision	___	___

RESPIRATORY	YES	NO
Difficulty breathing	___	___
Cough	___	___
Shortness of breath	___	___
Coughing up blood	___	___
Wheezing/Asthma	___	___

DIGESTIVE SYSTEM	YES	NO
Abdominal pain	___	___
Nausea	___	___
Vomiting	___	___
Bloating	___	___
Diarrhea	___	___
Constipation	___	___
Blood in stool	___	___
Frequent belching	___	___
Acid reflux	___	___

URINARY SYSTEM-FEMALE	YES	NO
Irregular periods	___	___
Menopausal-no periods	___	___
Hysterectomy	___	___
Vaginal discharge	___	___
Difficulty urinating	___	___
Blood in urine	___	___

NERVOUS SYSTEM	YES	NO
Dizziness	___	___
Loss of consciousness	___	___
Seizures	___	___
Blackouts	___	___
Nervous exhaustion	___	___
Strokes	___	___

EMOTIONAL STATUS	YES	NO
Nervousness	___	___
Mood changes	___	___
Schizophrenia	___	___
Depression	___	___
Insomnia	___	___

BLOOD/LYMPH SYSTEM	YES	NO
Anemia	___	___
Easy bruising	___	___
Easy bleeding	___	___
AIDS/HIV	___	___
Swollen glands	___	___

HEAD	YES	NO
Frequent headaches	___	___
Recent trauma	___	___

EARS/NOSE/THROAT MOUTH	YES	NO
Loss of hearing	___	___
Ringing in ears	___	___
Gum problems	___	___
Bleeding	___	___
Nose bleeding	___	___
Hoarseness	___	___
Difficulty swallowing	___	___
Morning cough	___	___
Toothache	___	___
Vertigo	___	___

HEART	YES	NO
Chest pain	___	___
Heart beating fast	___	___
Difficulty breathing w/activity	___	___
Elevated cholesterol	___	___

URINARY SYSTEM-MALE	YES	NO
Penile discharge	___	___
Difficulty urinating	___	___
Blood in urine	___	___
Nighttime urination	___	___
Prostate trouble	___	___
Burning with urination	___	___

MUSCLES/BONES	YES	NO
Pain	___	___
Weakness	___	___
Joint swelling	___	___
Backache	___	___
Degenerative disc disease	___	___

SKIN	YES	NO
Skin cancer	___	___
Rash	___	___
Non-healing lesion	___	___

ENDOCRINE/GLANDS	YES	NO
Thyroid problems	___	___
Heat intolerance	___	___
Cold intolerance	___	___
Diabetes	___	___
Excessive thirst	___	___
Excessive hunger	___	___
Frequent urination	___	___

ALLERGIES	YES	NO
None/Normal	___	___
Hay fever	___	___
Environmental allergies	___	___

_____ _____

Patient Signature attests to the accuracy of this document **Date**

KENNETH J. GALANG, M.D., P.A.
13710 METROPOLIS AVENUE, SUITE 110
FORT MYERS, FLORIDA 33912

PAIN MANAGEMENT AGREEMENT

This Pain Management Agreement between_____(patient) and Kenneth J. Galang, M.D (herein referred to as "provider" or "prescriber") is designed to:

- Create an open conversation between the patient and prescriber about the benefits, risks, and limitations of opioid medicines, and
- Be used as a decision-making tool before an opioid medicine is used for acute or persistent pain, and
- Educate the patient and prevent misunderstandings about certain medicines the patient may be taking for pain management, and
- Ensure the appropriate and safe use of opioid medicines is in compliance with the laws regarding controlled medication.

This agreement relates to my use of controlled medication for chronic pain prescribed by Kenneth J. Galang, M.D., a physician at Rehabilitation Medicine and Pain Management Specialist. I have been informed and understand the policies regarding the use of controlled medication that are followed by the staff of Kenneth J. Galang, M.D. I understand that I may be provided controlled medication while actively participating in this program **ONLY** if I adhere to the following conditions:

Part 1: Deciding whether to use opioid medicines for pain management purposes.

1. I understand that Dr. Kenneth J. Galang and I will work together to find the most appropriate treatment for my chronic pain. I understand the goals of treatment are not to eliminate pain but to control my pain to improve my ability to function and quality of life. Chronic Opioid therapy is only **ONE** part of my overall pain management plan.
2. I understand that Dr. Galang and I will **continually** evaluate the effect of opioids on achieving the treatment goals and make changes as needed. I agree to take the medication only at the **DOSE** and **FREQUENCY** and all other specifications as prescribed by Dr. Galang. I agree not to increase the dose of opioids on my own and understand that doing so may negatively impact overall health and lead to the discontinuation of opioid therapy.
3. I recognize that my chronic pain is a complex problem, which may be addressed by physical therapy, injections, psychotherapy, behavioral medicine, and other pain control strategies. I agree to cooperate and actively participate in **all** aspects of the pain management program to maximize functioning and improve coping with my condition. If treatment for my condition is available, I agree I will not refuse the treatment just so the opioids will be continued. I understand that I have the right to refuse any procedure, but that does **not** mean that Dr. Galang must continue to prescribe narcotic or opioid medications.
4. I have read, recognize, and understand the following side effects regarding the use of taking opioid medicines:
    a. **Physical dependence:** If I suddenly stop taking an opioid medicine, I can experience withdrawal symptoms such as a runny nose, chills, body aches, diarrhea, sweating, nervousness, nausea, vomiting, and trouble sleeping. This is called physical dependence. If this happens, it can be difficult for me to stop taking an opioid medicine, even if it's not working well. So, when I stop taking an opioid medicine, I understand I will need medical supervision. My prescriber can help me

gradually lower, or taper, the opioid medication dose and stop the opioid medicine. If necessary, I will permit my prescriber to refer me to an addiction specialist.

b. **Tolerance:** Over time, I might need more opioid medicine to get the same pain relief. This is called tolerance. It means that the opioid medicine may begin to feel like it's not working anymore. My prescriber can help me by making changes to the opioid medicine or refer me to a specialist in a way that meets my needs.

c. **Addiction:** I may develop an intense craving for the opioid medicine, even if I take it as prescribed. When a person is not able to control their opioid medicine use and may continue using the medicine despite the side effects it causes, this is called addiction. If addiction occurs, it can be difficult to stop taking the opioid medicine, and I will need medical supervision. My prescriber can help me gradually lower, or taper, the opioid medication dose and stop the opioid medicine. If necessary, I will permit my prescriber to refer me to an addiction specialist.

d. **Additional opioid side effects:** I understand that studies[1] have shown that opioids may cloud judgment and affect reflexes and motor skills. I will not participate in activities that would endanger myself or others while using opioid medications. The table[2] below lists common and potential opioid side effects in alphabetical order and the percentage of patients that experience them.

Opioid Side Effects	Percentage of Patients
addiction	5 - 30%
breathing problems during sleep, disruption of sleep	25%
confusion	*
constipation	30 - 40%
depression	30 - 40%
drowsiness	15%
dry mouth that can cause tooth decay	25%
intestinal blockage	<1% per year
itching	*
lowered testosterone levels, infertility and impotence	25% - 75%
nausea or vomiting	*
overdose – can lead to death	< 1% per year
physical dependence	*
tolerance	*
unexpected increased pain	*

*Percentage of patients experiencing side effect unknown

[1] van Steenbergen H, Eikemo M, Leknes S. The role of the opioid system in decision making and cognitive control: A review. Cogn Affect Behav Neurosci. 2019 Jun;19(3):435-458. doi: 10.3758/s13415-019-00710-6. PMID: 30963411; PMCID: PMC6599188.

[2] AnGee Baldini, Michael Von Korff, and Elizabeth H. B. Lin. A Review of Potential Adverse Effects of Long- Term Opioid Therapy: A Practitioner's Guide. Primary Care Companion CNS Disorders 2012; doi:10.4088/PCC.11m01326.

5. If it appears to Dr. Galang that there are no demonstrable benefits to my daily function or quality of life from the controlled medication, I will agree to gradually taper my medication as directed by my provider.
6. Taking even small amounts of alcohol or taking medicines such as sleeping pills, antihistamines, and anti-anxiety medicines while taking an opioid medicine may increase the chance of opioid medicine side effects. These side effects can include drowsiness, dangerously slowed breathing, and decreased alertness. I agree to not abuse any of the aforementioned substances while under the care of my prescriber.
7. As required by law, **I will submit urine for random drug testing four times a year to determine my compliance with their program of pain control.** I agree to pay **$70.00** for Urine Drug Screening if my insurance does not cover it or if my insurance does not pay for the service. I agree to pay **$120** for the Urine Drug screening if I am Self Pay with no insurance. Refusing a urine drug test will result in being discharged from the practice.
8. I agree to discuss with my prescriber my and my family's past and present use of any habit-forming substances before we decide to treat my pain condition with an opioid medicine. These habit-forming substances can include tobacco and alcohol, as well as other opioid medicines or street drugs.

Part 2: My (the Patient's) promise to using opioid medicines safely.

9. I agree to inform my provider about all the medicines I am taking, including any prescription, over the counter, and herbal medicines. I will also discuss with my provider any new medicine that I take in the future. Some medicines and other substances such as alcohol, sleeping medicines, antihistamines, and anti-anxiety medicines can increase the chance of opioid medicine side effects. If I use these medicines along with an opioid medicine, they can slow my breathing. This can lead to serious problems, including an increased chance of stopping breathing and death.
10. If I start to have more pain or other unusual or severe side effects, I will contact my prescriber right away. We may need to change the dose or try a different medication. I will not make any changes to the opioid medicine without first talking to my prescriber.
11. I will inform my prescriber if I am pregnant or planning to become pregnant. Taking opioid medicine during pregnancy can harm my unborn baby.
12. I agree I will not use any illegal controlled substances, including but not limited to marijuana, cocaine, heroin, etc. I agree to not use any prescription medications obtained illegally.
13. I agree I will not share, sell, or trade my medication.
14. I agree to protect my pain medicine from loss or theft. Lost or stolen medicines will not be replaced. I will report stolen medication to the police and to my provider and will produce a police report of this event. If someone accidentally takes some of my opioid medicine or I accidentally take too many doses, I will contact my prescriber or call the **Poison Control Center at 1-800-222-1222.**
15. I will remove expired, unwanted, or unused opioid medicine from my home to avoid accidentally harming children, other adults, or myself.
    a. I will properly dispose of unused opioid medicine as directed by my prescriber.
    b. I can get more information about disposing of my opioid medicine by calling 1-888-FDA-INFO (1-888-463-6332) or at the following website http://www.fda.gov/drugs/resourcesforyou/consumers/buyingusingmedicin

esafely/ensuringsafeuseofmedicine/safedisposalofmedicines/ucm186187.htm

16. I agree to bring in all unused pain medicine in the original bottles at every appointment with my prescriber.
17. I agree I will not attempt to obtain any opioid medicines from another doctor or provider without informing Dr. Galang first. I agree to have my opioid prescriptions filled only at_____ __ . (List pharmacy name and phone number).
18. I agree that refills of my prescriptions for pain will be made only at the time of an office visit or during regular office hours. No routine refills will be available during evenings, after 4 pm, or on weekend, holidays, or through the emergency room. Medications will not be mailed or refilled without being seen at **monthly** pain clinic appointments (if patient is receiving his opioids from the pain clinic). **I understand that I can no longer pick up Scheduled narcotic medication without being seen, according to the law.**
19. I am responsible for keeping track of the number of medications left and to plan ahead for arranging the refill of my prescriptions in a timely manner.
20. I will accept generic brands of my prescription medications.

Part 3: For the patient and the prescriber

21. I will attend all appointments, treatments, and consultations as requested by my provider. I will attend all pain appointments and follow pain management recommendations. I understand that failure to keep appointments may lead to discontinuation of treatment.
22. I will verbally inform my providers about the level and description of my pain, the effect of the pain on my daily life and how well the medicine is helping to relieve my pain.
23. I understand that if I violate any of the above conditions, Dr. Galang may choose to stop writing opioids prescribed for me. Discontinuation of the medications will be coordinated by Dr. Galang and may require specialist referrals.
24. I understand that, if the provider deems it necessary, Dr. Kenneth J. Galang will cooperate fully with any official entity, including but not limited to the state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of pain medicine.
25. I understand that if I am **verbally or physically abusive** to any staff member at Kenneth J. Galang, M.D., P.A. or engage in any illegal activity (including but not limited to altering a prescription), that the incident may be reported to other physicians, local medical facilities, pharmacies, and other authorities such as the local police department, Drug Enforcement Agency, etc. as deemed appropriate for the institution. I understand and accept that such illegal actions may lead to consequences including discontinuation of treatment or being discharged from the practice.
    a. I understand that my provider upholds the physician's obligation to nonabandonment[3]. Patient abandonment occurs when a clinician-patient relationship has been established, the clinician stops the treatment abruptly (without giving the patient time to seek an alternative care provider), and that cessation of care causes harm (or potential harm. The provider is not required to continue to provide care to patients who are physically or verbally abusive, to provide treatments they find to be disproportionately harmful, to be available at all hours, or to take part in procedures

[3] D Chatwal, M. S., Kamal, A. H., & Marron, J. M. (2023). Fear of saying no (FOSNO): Setting boundaries with our patients and ourselves. American Society of Clinical Oncology Educational Book, (43). doi:10.1200/edbk_390598

to which they are personally opposed.

b. Instead, as long as the patient's care can be safely transferred to another clinician/institution, these professional obligations are met.

Medication Refill Information:

1. Advance notice of 4 business days is required for all **non-opioid** refills of the prescriptions.
2. Requests for scheduled refills for **non-opioids** must be telephoned to the pharmacy only during regular office hours Monday-Friday (8:30 am – 4:00 pm). Refills will **not** be made at night, on holidays, or on weekends.
3. According to the law, **prescriptions for Schedule 2 narcotics may only be picked up or sent electronically when you are seen by the physician.**
4. You will be given a (30) thirty day supply each month, if indicated.

- **This agreement will supersede all other agreements.**
- **By signing below, I indicate that I understand and agree to all the terms of the above agreement. I have received a copy of this for my own records.**

Patient _____ (Print Name) DOB: _____

Patient _____ (Signature) (Date) : _____

Witness _____ (Signature) (Date) : _____

Provider Dr. Kenneth J. Galang (Print Name)

Provider _____ (Signature)

Kenneth J. Galang, M.D., P.A.

FINANCIAL POLICY (2025)

I **authorize financial information and reports** of my evaluation, treatments, and any follow-up evaluations to be sent to or discussed with my referring doctor requesting consultation, my family physician, as well as any other healthcare providers, hospitals or outpatient facilities that I have or will identify to you.

I authorize any holder of medical or other information about me, to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agents of my insurance companies or to my employer if this is a worker's compensation claim, any information needed for this or related insurance or Medicare claim. I permit a copy/fax of this authorization to be used in place of the original and request payment of medical insurance benefits to myself or to the party who accepts assignment. If I have been tested for or have contracted Autoimmune Deficiency Syndrome (AIDS)/Human Immunodeficiency (HIV), I authorize the release of the fact and/or results of testing to any of the individuals, healthcare providers or third-party payers related to my care. (This practice does not provide or perform testing for the virus.)

I understand that I am fully and legally responsible for all charges for services rendered which include all outstanding balances not covered by Medicare and/or insurance companies. In the event, I fail to pay any outstanding balance, I also agree to pay all billing fees, collection agency fees, and attorney fees and court costs, if any.

NO SHOW POLICY/LATE CANCELLATION

I understand that I will be charged: **$75.00** if I miss a regular appointment or **$150.00** if I miss an appointment for a procedure **or** fail to cancel at least 24 hours before my scheduled appointment.

AUTHORIZATION POLICY

I understand that I will be charged the amount of **$35.00** for any Prior Authorization Request for Medications that my insurance is requiring for me to get the medication Dr. Kenneth Galang, MD., PA. prescribes. I understand that I will be charged the amount of **$35.00** for any authorizations acquired for procedures if I decide not to continue with the procedure.

URINE DRUG SCREENING POLICY

I understand I will be charged **$70.00** if my insurance does not pay for or denies the Urine Drug Screening Test done here in the office. I understand our in-office Urine Drug Screening must be done no less than four times a year according to the Florida State Department of Health and Pain Management Statutes.

CONVENIENCE FEE

Credit and debit card payments are subject to an additional, non-refundable **$4.00** charge for every $99.00 charged.

BCBS Grace Period

If I am in the BCBS grace period, my insurance is considered inactive and I will be charged $330/office visit and $70/UDS. (The UDS charges are not refundable)

WE DO NOT ACCEPT PERSONAL CHECKS

Patient Name: _____ Date of Birth: _____ Patient Signature: _____ Date signed: _____

Guarantor Name: _____ Guarantor Signature: _____ Date signed: _____

KENNETH J. GALANG M.D. P.A.
13710 Metropolis Avenue
Suite 110
Fort Myers, FL 33912
Office (239) 225-0129
Fax (239) 225-0575

PATIENT'S ACKNOWLEDGEMENT OF RECEIPT OF MEDICAL INFORMATION PRIVACY NOTICE

I hereby acknowledge that I received the Dr. Kenneth J. Galang M.D., P. A. Medical information Privacy Notice for my review prior to receiving services through Dr. Kenneth J. Galang M.D., P.A.

_____ _____

Signature of Witness

(If Patient Signs with an "X")

Signature of Patient or

Patient's Representative

_____ _____

Print Name of Witness

Print Name of Patient or

Patient's Representative

_____

Relationship of Patient's

Representative To Patient

_____

Date

KENNETH J. GALANG, M.D., P.A.
13710 Metropolis Ave, Suite 110
Fort Myers, FL 33912
Office: (239) 225-0129
Fax: (239) 225-0575

Authorization for the Use and Disclosure of Protected Health Information (PHI)

This form is used to authorize Kenneth J. Galang, M.D., P.A. to disclose protected health information to the person/entity designated below. Please complete the following information. All sections must be completed or the form will be considered incomplete and returned to you.

SECTION 1: DEMOGRAPHIC INFORMATION:

Patient Name: _____ **Phone Number:** _____
Street/PO Box: _____
City: _____ **State:** _____ **Zip:** _____

SECTION 2: PURPOSE OF THE AUTHORIZATION:

Please note that by signing this form, you will authorize Kenneth J. Galang, M.D., P.A. to disclose your protected health information for the following purpose. Describe the purpose of the authorization.

_____
_____

SECTION 3: PROTECTED HEALTH INFORMATION TO BE DISCLOSED:

Please indicate the specified protected health information you authorize us to disclose for the purposes stated above. (What Document):

_____
_____

SECTION 4: PERSON/ENTITY AUTHORIZED TO RECEIVE:

Please indicate the person and/or entity name and address to which you are authorizing Kenneth J. Galang, M.D., P.A. to disclose the protected health information described above.

Name/Entity: _____
Relationship to Patient: _____ **Phone Number:** _____

Name/Entity: _____
Relationship to Patient: _____ **Phone Number:** _____

SECTION 5: EXPIRATION:

This authorization will expire in one year from the date of signature unless you indicate another date below.

On: _____ /_____ /_____

_____
Patient Date of Birth

_____
Date

_____
Signature of Patient or Legal Representative