



NEW PATIENT PAPERWORK

PATIENT INFORMATION

Today's date: _____

Mr. Mrs. Ms. Dr. *(circle one)* Name: First _____ MI _____ Last _____

Mailing Address: _____ City _____ State _____ ZIP _____

Physical Address: _____ City _____ State _____ ZIP _____

SS#: _____ Birthdate: _____ Male Female

School: _____ Grade: _____

Student Email: _____ Student Cell Phone #: _____

Primary Care Physician *(Shown on Insurance Card)*: _____ Phone: _____

Dentist: _____ Phone: _____

Names of siblings enrolled in Tensas School-Based Health Center: _____

Primary Care Physician *(Shown on Insurance Card)*: _____

Preferred Language: _____

Race: *(check one)* American Indian or Alaska Native Asian Black or African American
 White Native Hawaiian or Other Pacific Islander More than one Race

Ethnicity: *(check one)* Hispanic or Latino Not Hispanic or Latino

Sexual Orientation: *(check one)* Straight/Heterosexual Lesbian Gay Bisexual
 Refuse to Answer Other *(explain)* _____

Gender Identity: *(check one)* Male Female Transgendered Refuse to Answer
Other *(explain)* _____

PARENT/ GUARDIAN INFORMATION

Mr. Mrs. Ms. Dr. *(circle one)* Name: First _____ MI _____ Last _____

Home #: _____ Work #: _____ Cell#: _____

Billing Address: _____

SS#: _____ Birthdate: _____ Male/Female _____

Relationship to Patient: _____

EMERGENCY CONTACT *(Neighbor or Relative not living with you)*

His/Her Name: _____ Relation: _____

Home #: _____ Work #: _____ Cell#: _____



NEW PATIENT PAPERWORK CONT.

INSURANCE INFORMATION *(Please check the type of health insurance:)*

___ **Medicaid/Healthy Louisiana Plan** *(formerly Bayou Health)* #: _____

Amerigroup Real Solutions LA AmeriHealth Caritas LA Aetna Better Health LA

LA Healthcare Connections United Healthcare Community Plan LA

___ **Medicaid (dental)** #: _____

___ **Medicare** #: _____

___ **No Insurance**

___ **Private/Other Insurance Name** _____

Employer/ Address: _____ Phone #: _____

Policy #: _____ Group #: _____ Effective Date: _____

Name of policy holder: _____ Relation: _____

Policy holder date of birth: _____ Policy holder Social Security #: _____

Does your insurance pay for prescriptions? No Yes Dental Coverage? No Yes

___ **Secondary Insurance Name** _____

Employer/ Address: _____ Phone #: _____

Policy #: _____ Group #: _____ Effective Date: _____

Name of policy holder: _____ Relation: _____

Policy holder date of birth: _____ Policy holder Social Security #: _____

Does your insurance pay for prescriptions? No Yes Dental Coverage? No Yes

PREFERRED PHARMACY

Name: _____ Street: _____ Phone: _____



STUDENT'S NAME _____ 2ND IDENTIFIER _____

MEDICAL AND HOSPITALIZATION INFORMATION:

Is your child allergic to any food? Medicine? Insect? Latex? Other? ___ No ___ Yes

If yes, list: _____

List of current medications student is on with dosage (how much) and how often:

Has your child been admitted into a hospital or had surgery: ___ No ___ Yes If Yes, Year: _____

Reason: _____ Hospital: _____

Date of last comprehensive physical/well check ___/___/___

Performed by PCP _____ or Someone else _____

PLEASE MARK THE ITEM(S) THAT APPLY TO YOUR CHILD'S MEDICAL HISTORY:

- | | | |
|---|---|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Behavior Problems | <input type="checkbox"/> Endocrine (<i>Diabetes, Thyroid, Pituitary</i>) |
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Depression | <input type="checkbox"/> Infectious Disease (<i>Hepatitis, HIV, TB, Meningitis</i>) |
| <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Missing Organ (<i>Kidney, Eyes, Testicles</i>) |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Blood Disorder |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> ADHD | <input type="checkbox"/> Birth Defects - Genetic Disorder |
| <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Heart Disease/Murmur Reasons | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Ear or Sinus infections | <input type="checkbox"/> Been Restricted from Sports/PE |
| <input type="checkbox"/> Major Injuries | <input type="checkbox"/> Hearing & Speech Problems | <input type="checkbox"/> Other (specify) _____ |

Please describe any item marked: _____

FAMILY HISTORY:

Please mark the item(s) that apply to your family's history: (*B=brothers, S= sisters, P= parents and G=grandparents*)

- | | | | |
|-----------------------------------|--|--|---------------------------------------|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Depression | <input type="checkbox"/> Genetic Disorder | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Sickle Cell | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Heart Disease/Heart Problem | |
| <input type="checkbox"/> Allergy | <input type="checkbox"/> ADHD | <input type="checkbox"/> High Blood Pressure | |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Other (specify) _____ | |

Please describe any item marked (Who/When): _____

ALL SERVICES ARE PROVIDED BY LICENSED PROFESSIONALS

By signing this consent, you are agreeing to allow the School-Based Health Center to provide the following services to your child:

- Primary And Preventive Health Care
- Comprehensive History And Physical Examinations
- Immunizations
- Health Screenings
- Laboratory/Diagnostic Testing
(Including testing for sexually transmitted infections and/or HIV, if separate consent is not required by law)
- Management Of Chronic Diseases
- Acute Care For Minor Illness And Injury Including Medications, If Indicated
- Behavioral Health Services
- Referral And Follow-Up For Emergencies
- Case Management
- Referral To Specialty Care
- Health Education And Prevention Programs
- Dental Services (Provided By Tensas Dental Clinic)

MEDICATION CONSENT:

Tensas School-Based Health Center will administer medications with the NP and/or Doctor's orders. Over-the- Counter medications may be administered such as Pain Relievers, Cold Medications, Ear Drops, Eye Drops, Stomach Medication (Pepto-Bismol, Mylanta, Midol), Wound Medications, Anti-Itch Medication, and other topical cream/gels for other complaints, such as Orajel, Carmex, or Vaseline. Prescription medication may be given if found necessary after examination as well. Antibiotic injections such as Rocephin may be given if deemed necessary by the NP or MD. Nebulizer medications may be administered for asthma type symptoms, if necessary, for treatment of students. Age appropriate Immunizations will be given to bring the student up to date according to the CDC guidelines, if the student is not up to date at the time of the exam.

I understand this student may receive all medications offered at the School-Based Health Center except those which I have written here: _____

IMMUNIZATION CONSENT:

Age appropriate immunizations, including the Flu and HPV vaccines, **will be given** to bring the student up to date according to the CDC guidelines, if the student it not up to date at the time of the exam.

I understand my student may receive all immunizations offered at the School-Based Health Center except those which I have written here or checked below: _____

I DO NOT WANT CHILD TO HAVE: *(please check below if you do not want your child to receive either the flu or HPV vaccine):*

___ **FLU VACCINE** – Flu is caused by influenza viruses, and is spread mainly by coughing, sneezing, and close contact. Anyone can get the flu, but the risk of getting flu is highest among children. Each year thoughts of people in the United State die from flu, and many more are hospitalized, This vaccine will help prevent contraction of the flu virus.

___ **HPV VACCINE-** This vaccine is recommended for males and females ages 11-26 years of age. HPV is the most common sexually transmitted virus in the United States. This vaccine can prevent most cases of cervical cancer in females, if it is given before exposure to the virus. In addition, if can prevent vaginal and vulvar cancer in females, and genital warts and anal cancer in both male and females.

TELEMEDICINE:

I hereby authorize the use of telemedicine (defined as the use of medical information exchanged from one site to another via electronic communications for the health of the patient, including consultative, diagnostic, and treatment services) may be employed to facilitate my medical care. I understand the rationale for using telemedicine in place of in-person services, as well as the risks and benefits of the utilization of telemedicine, including privacy related risks, and acknowledge that all electronic transmission of data will be restricted to authorized recipients in compliance with the Federal Health Insurance Portability and Accountability Act (HIPPA) and applicable state privacy laws. I acknowledge that I have had the opportunity to ask my questions regarding the use of telemedicine and the risks and benefits of alternative methods, including the risks and benefits of no treatment.



CONFIDENTIALITY:

The School-Based Health Centers (SBHCs) adhere to all current laws regarding confidentiality of health services in general and specifically as they relate to services to minors. All medical and mental health records are confidential and will be maintained as directed by the Health Insurance Portability and Accountability Act (HIPAA). I consent to the exchange of relevant health information between Tensas School-Based Health Center and the student's personal medical provider upon referral for medical care. I have been given a copy of the organization's Notice of Privacy Practices that describes how my health information is used and shared. I understand that Tensas Parish School-Based Health Center has the right to change this notice at any time. I may obtain a current copy by contacting the School-Based Health Center or their website. My signature on this consent constitutes my acknowledgement that I have been provided a copy of the Notice of Privacy Practices.

LAHIE STATEMENT:

We understand that the SBHC may participate in one or more health information exchanges (HIEs), whereby the center may share my health information with other health care providers for treatment, payment or health care operations purposes. We hereby consent to the disclosure of the SBHC's records into the HIEs.

I, as parent/guardian, understand that I will not be charged for any of the services provided at the School-Based Health Center. I also understand that Tensas Community Health Center or the medical provider may bill Medicaid or other insurance providers for these services. I authorize/assign payments of authorized benefits directed to Tensas Community Health Center,

By signing below, we (student and parent/guardian) acknowledge that we have read and understand the services to be provided at the School-Based Health Center. We both give permission for this student to receive the services provided by the program.

This consent is effective while the student is enrolled in any school within Tensas Parish unless the School-Based Health Center is notified in writing, that I no longer wish for my child to receive services. That form may be obtained from my nearest health center. I also understand that I may be asked update important information every year.

We also understand Tensas School-Based Health Center is operated by Tensas Community Health Center and its employees and contractors.

Printed Name of Parent/Legal Guardian/Student

Relationship

Signature of Parent/Legal Guardian

Date

Signature of Student (optional)

Date

This consent may be withdrawn or modified at any time with written permission of the parent/guardian and student to the entity referred to above. A duplicate copy of this document will be given to parents or guardians upon request.



TRANSPORTATION CONSENT

STUDENT'S NAME _____ DATE OF BIRTH _____

I consent to my child being transported by van or shuttle bus by TCHC from my child's school to Tensas School-Based Health Center or TCHC or Tensas Dental if necessary. I understand that the Tensas Parish School Board has no involvement in transporting my child and that no one from the School Board will accompany my child while riding in the TCHC's van/bus. I acknowledge, that during transportation, my child will be under the sole supervision of TCHC. I release the School Board from any damages of injuries my child may sustain while being transported by TCHC.

Printed Name of Child

Printed name of Parent/Legal Guardian

Child's Date of Birth

Parent/Legal Guardian Signature

Phone Number

Date

TENSAS SCHOOL-BASED HEALTH CENTER

916 Plank Road

Saint Joseph, LA 71366

Phone: (318) 766-1080



STUDENT NAME: _____ **STUDENT DATE OF BIRTH:** _____

Does your Student have a dentist he/she sees routinely? ___No ___Yes - Dentist's Name: _____

When did your student last have their teeth cleaned? ___Not Sure ___6 months ago ___12 months Ago

When did your student last have dental X-rays taken? _____

How often does your student eat sweets, Mints, or chews sugar gum? List Type:

___Everyday ___Once/week ___Once/Month ___Hardly Ever

How often/when does your student drink soda or other sweet drinks? _____

Is your student having medical or dental problems, pain or discomfort at this time? ___No ___Yes

If so, please describe: _____

Has your student ever experience any complications of any kind during dental treatment? ___No ___Yes

If yes please explain: _____

Is your student allergic to latex? ___No ___Yes ___I don't know

I consent for my child to receive the following dental services from Tensas Dental Clinic:

DENTAL CLEANING- Dental cleanings involve removing plaque (soft, sticky film) and tartar that has built up on the teeth over time, polishing the teeth, x-rays, fluoride treatment.

CAVITY FILLINGS- The dentist will remove the cavity (decayed portion of the tooth) and then "fill" the area on the tooth where the cavity was removed. The filling material can be either white (composite) or silver (amalgam). Most cavity fillings require the tooth to be numbed.

SEALANTS- Protectant material that coats the chewing surface of the bath teeth to prevent cavities.

Potential complications from these procedures include, but are not limited to, sensitivity, swelling and bleeding of the gums.

Any additional dental services will have a separate consent to be signed at the time the services are provided. The patient's medical history will be updated at every visit. If your student has a dentist that he/she sees on a regular basis, we encourage you to continue to seek care through that provider. The parent/guardian may be present for all dental visits. If you wish to be present when dental services are provided, you must contact the clinic noted below. **I, a parent/guardian understand that I will not be charged for any of the services provided through Tensas Dental Clinic.** I also understand TCHC or the dentist may bill Medicaid or other insurance providers for these services. I authorize/assign payments of authorized benefits directed to Tensas Community Health Center. I understand that the dental services billed to the student's insurance company may be counted towards any annual benefit limitations. I attest that I am the parent or legal guardian of this student and have legal authority to sign this consent form.

Printed Name of Parent/Legal Guardian/Student

Relationship

Signature of Parent/Legal Guardian

Date



MEDICAL RELEASE FORM

As required by the Health Insurance Portability and Accountability Act (HIPPA) of 1996, TVCHC may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the use and disclosure of protected health information described herein.

I, _____ understand that the information contained in my record is confidential. However, I give consent of _____

At _____ to release all of my records or information concerning such records to **Tensas School-Based Health Center.**

I understand that the document authorized to be released by me include, but are not limited to, family histories, reports of clinic findings and diagnosis, laboratory test, X-rays, reports of examination and/or evaluation, and any hospital admission or discharge records.

I understand that I may revoke this consent at any time except to the extent that action has been taken thereon. I further understand that this consent will expire upon _____ (not to exceed six months) and cannot be renewed without my written consent.

Signature _____

Signature of Witness _____

PATIENT IDENTIFYING DATA

Name: First _____ MI _____ Last _____

Address: _____ City _____ State _____ ZIP _____

SS#: _____ Birthdate: _____

TENSAS SCHOOL-BASED HEALTH CENTER

916 Plank Road

Saint Joseph, LA 71366

Phone: (318) 766-1080



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Please return this form to Dawn Johnson, Privacy Officer at 402 Levee Street Saint Joseph, LA 71366 acknowledging your receipt and review of Tensas Community Health Center, Inc.'s Notice of Privacy Practices.

Name: _____

Signature: _____

Relationship if not Patient: _____

Date: _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY, SIGN THIS FORM, AND RETURN TO THE RECEPTIONIST.

OUR COMMITMENT

Tensas Community Health Center, Inc. (“Clinic”) remains committed to protecting the privacy of our patients’ protected health information (“PHI”) and is dedicated to complying with laws governing the privacy of PHI. This Notice explains our privacy practices, legal duties, and your rights concerning your PHI. PHI includes information about your health care and treatment combined with information like your name, age, birth date, address, or financial information. This Notice is effective as of August, 24, 2020 and will remain in effect until revised.

We protect your PHI by:

- Treating all PHI as confidential.
- Maintaining policies and practices that govern our staff in handling your PHI, as well as provide sanctions for violations.
- Restricting access to your PHI to only those that need it in providing services to you.
- Disclosing only the PHI that is minimally necessary for an outside service to perform a function on behalf of the Clinic and requiring that they agree to confidentiality of PHI disclosed.
- Maintaining administrative, physical, and technical safeguards to protect your PHI.

TYPES OF USES AND DISCLOSURES OF YOUR PHI

We will use and disclose health information about you for treatment, payment and health care operations. For example:

- **Treatment:** We may use and disclose your PHI to other healthcare providers currently treating you to assist in such treatment.
- **Payment:** We may use and disclose your PHI to obtain payment for services we provide to you.
- **Healthcare Operations:** We may use and disclose your PHI for our healthcare operations, including quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training and educational programs, accreditation, certification, licensing, or credentialing activities.

OTHER PURPOSES FOR WHICH CLINIC IS AUTHORIZED TO USE OR DISCLOSE YOUR PHI

- **Your Authorization:** In addition to our use of your PHI for treatment, payment, or healthcare operations, you may give us written authorization to use or disclose your PHI for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.
- **Persons Involved in Care:** We may use or disclose PHI to notify, or assist in the notification of a family member, your personal representative, or another person responsible for your care, of your location, general condition, or death. If you are present and capacitated, then we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will use our professional judgment to determine if disclosure is in your best interest and only disclose PHI that is directly relevant to the person's involvement in your care.
- **Required by Law:** We may use or disclose your health information when we are required to do so by law, including, but not limited to, court orders, warrants, subpoenas, discovery requests, or other lawful process.
- **Public Health Activities:** We may use or disclose your PHI to a public health authority for public health activities such as preventing the spread of a communicable disease.
- **Abuse or Neglect:** We may disclose your PHI to a government authority if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the possible victim of other crimes.
- **To Avert a Serious Threat to Health or Safety:** We may disclose your PHI to the extent necessary to avert a serious threat to health or safety.
- **Workers' Compensation:** We may disclose your PHI to a workers' compensation insurer when related to treatment of an injured worker.
- Clinic will not use or disclose your psychotherapy notes or any PHI for marketing or sale. However, PHI may be used or disclosed in connection with the future sale of all or part of Clinic. In the event that PHI is used for fundraising purposes, you have the right to opt out of such communications.

PATIENT RIGHTS

You have the right to request all of the following:

- **Restriction Requests:** You have the right to request a restriction on the uses and disclosures of your PHI. Although we are not always required to grant a restriction, those granted will be upheld. Further, you have the right to request restriction, and such request will be granted, regarding certain disclosures of PHI to a health plan where the individual or someone on his or her behalf pays out of pocket for the health care item or service provided.
- **Confidential Communication:** You have the right to request that communication containing PHI be conducted in an alternate way or at an alternate location.

- **Your Right to Inspect PHI:** You have the right to request and inspect your PHI, subject to reasonable copying expenses. Inspection will not be allowed if we determine that the information could be harmful to you or another person or if it involves psychotherapy notes, records compiled in reasonable anticipation of litigation, or PHI whose release is prohibited by federal or state laws.
- **Amendment:** You have the right to request an amendment to your PHI in writing.
- **Accounting of Disclosures:** You have the right to request an accounting of disclosures of your PHI, outside of those disclosures permitted without authorization, for the past six (6) years. The accounting will include: the date, name of person or entity, description of the PHI disclosed, the purpose of the disclosure, and other related information. If more than one (1) accounting is requested in a twelve (12) month period, a reasonable fee may be charged.
- **Electronic Notice:** If you received this notice by electronic means, you are entitled to request a paper copy.

DUTIES OF THE CLINIC

Clinic is required by law to maintain the privacy of PHI, to provide this Notice, and to notify affected individuals following a breach of unsecured PHI. Moreover, Clinic is required to abide by the terms contained in this Notice. Clinic reserves the right to change this Notice and make the new Notice effective for all PHI we maintain. In the event of a change, the revised Notice will be posted in the waiting room and website of the Clinic.

COMPLAINTS

You have the right to complain to the Clinic, and to the Secretary of Health and Human Services if you believe your privacy rights have been violated. Complaints may be filed with the Privacy Officer at 402 Levee Street Saint Joseph, LA 71366. Clinic will not engage in any retaliatory acts in response to the filing of a complaint.



FAQS

What is a School-Based Health Center?

A school-based health center (SBHC) is a clinic located in the school or on school property that provides comprehensive primary medical, social, and behavioral health services, as well as health education, promotion, and prevention services to help minimize health-related absences from school and support the students for success in the classroom. The Tensas SBHC is operated by Tensas Community Health Clinic (TCHC) and adheres to state and federal laws, policies, and professional standards for provision of medical and mental health care.

What are the benefits of SBHCs?

SBHCs help reduce barriers that may prevent students from seeking health care services such as accessibility, transportation, cost, and confidentiality concerns. The Tensas SBHC is located on Tensas School Board property, next to Tensas High School, so students are able to receive the health care services they need and then return to learning in their classrooms. SBHCs also help eliminate the need for parents to take off time from work to take their child to a doctor. Students may be seen at the SBHC without their parent/guardian present, once consent is provided.

What are the hours of SBHC?

Tensas SBHC is open whenever school is in session.

What is the cost?

There is no copay for any child seen at a SBHC. TCHC will bill all insurance providers.

Do parents need to give permission for students to visit the SBHC?

Yes. Parents/guardians must sign consent forms in order for their children to receive care.

Can students make appointments during class time?

Yes. SBHCs want to help students stay in school and learn, so every effort is made to schedule appointments so that students are not absent from core classes.

Does a student need to be enrolled in the SBHC in order to use the services?

Yes. Only students who have enrolled in the SBHC can be seen by the Tensas SBHC provider, which includes a consent form signed by parent/guardian and a registration packet detailing patient information and health history. Enrollment documents may be found on the TCHC website: <https://www.tensashealth.com/school>

If my child is sick at home, can they be brought to the Tensas SBHC to be seen?

We encourage students who are sick at home to be seen at the main TCHC or by their primary care provider (PCP).

Does a student need to have health insurance to be seen at the SBHC?

No. Tensas SBHC provides care to students whether insured or uninsured. TCHC will bill private insurance and Medicaid for the services provided when appropriate.

What if the student already has a PCP?

If the student has a PCP, the Tensas SBHC staff will serve to supplement the student's health care. If necessary, and parent/guardian consent provided, the Tensas SBHC staff will communicate and collaborate with the PCP to ensure the student receives the best health care possible.

Can members of the community be seen at the Tensas SBHC?

No. Only students, faculty, and staff from any school within Tensas Parish, are allowed to receive services.

Will the SBHC provide prescription medication on site?

The Tensas SBHC may administer select medications on site, if deemed necessary by the provider, but all prescriptions will be sent to the pharmacy identified on the student's enrollment form.

TENSAS SCHOOL-BASED HEALTH CENTER

916 Plank Road

Saint Joseph, LA 71366

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To the Parent/Guardian of: _____

Our records indicate that your child may be due for one or more immunization(s). If your child has received these immunizations by another health care provider, please notify us so that the child's immunization record may be updated.

The following immunizations are required for school attendance:

To avoid delayed entry to school this upcoming year, please contact Tensas School-Based Health Center, Tensas Community Health Center at (318) 766-1967, or your child's primary care provider, to schedule an appointment to have your child vaccinated.

We look forward to hearing from you.

Thank you,

Edwina Eley, APRN, FNP-C

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916 Plank Road

Saint Joseph, LA 71366

Phone: (318) 766-1080



**PATIENT
REVIEW**

Today's date: _____

Mr. Mrs. Ms. Dr. (*circle one*) Name: First _____ MI _____ Last _____

Reason for today's visit: _____

Last menstrual period: _____ **ARE YOU PREGNANT? Y/N**

List any other doctors you currently use: _____

Do You: ___ Smoke Cigarettes ___ Use Tobacco Products ___ Drink Alcohol ___ Use Recreational Drugs?

Previous Surgeries or Hospitalizations? Please list with dates: _____

Current Medications: _____

Allergies _____

Pharmacy to be used today: _____

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