SYNERGY HEALTH PARTNERS

PATIENT NAME: _____

TODAY'S DATE: ___/___/_____

DATE OF LOSS: ___/___/_____

PATIENT INTAKE – AUTO V. AUTO

PATIENT PERSONAL INFORMATION

LAST NAME:	**FIRST NAME:**		**MIDDLE INITIAL:**
DATE OF BIRTH:	**AGE:**	**SOCIAL SECURITY NUMBER:**	
ADDRESS:	**CITY:**	**STATE:**	**ZIP:**
HOME PHONE: ( )	**MOBILE PHONE:** ( )	**WORK PHONE:** ( )	**MAY WE LEAVE A VOICE MAIL AT THESE NUMBERS?** ☐ Yes ☐ No
E-MAIL ADDRESS:	**HEIGHT:**	**WEIGHT:**	
MARITAL STATUS: ☐ Married ☐ Single ☐ Divorced ☐ Widowed	**HAND DOMINANCE:** ☐ Right ☐ Left	**GENDER:** ☐ M ☐ F	

EMERGENCY CONTACT INFORMATION

FULL NAME:	**RELATIONSHIP TO YOU:**
PHONE: ( )	**MAY WE LEAVE A VOICE MAIL AT THIS NUMBER?** ☐ Yes ☐ No

INSURANCE INFORMATION

(Please list the following information on the vehicle you were in at the time of the collision.)

VEHICLE OWNER:	**AUTO INSURANCE COMPANY:**	**AUTO INSURANCE COMPANY PHONE:** ( )	
YOUR RELATION TO VEHICLE OWNER:	**POLICY NUMBER:**	**CLAIM NUMBER:**	
MEDICAL PAYMENTS (MED-PAY) LIMITS: $	**UNINSURED MOTORIST LIMITS** $		
PERSON AT FAULT: ☐ Self ☐ Other – Name/Company:	**PERSON AT FAULT AUTO INSURANCE COMPANY (IF KNOWN):**		
AT FAULT AUTO INSURANCE PHONE: ( )	**AT FAULT POLICY NUMBER:**	**AT FAULT CLAIM NUMBER:**	
OTHER INSURANCE:	**INSURANCE COMPANY:**	**OTHER AUTO INSURANCE PHONE:** ( )	
POLICY NUMBER:	**CLAIM NUMBER:**	**MEDICAL PAYMENTS LIMITS:** $	**UNINSURED MOTORIST LIMITS:** $
DO YOU HAVE PERSONAL MEDICAL INSURANCE? ☐ Yes ☐ No	**NAME OF MEDICAL INSURANCE:**		

ATTORNEY INFORMATION

FULL NAME:	**NAME OF LAW FIRM:**		
ATTORNEY'S ADDRESS:	**CITY:**	**STATE:**	**ZIP:**
ATTORNEY'S PHONE: ( )	**ATTORNEY'S FAX:** ( )	**PARALEGAL HANDLING CASE (IF KNOWN):**	

INITIALS: _____

SYNERGY HEALTH PARTNERS

PATIENT NAME: _____

TODAY'S DATE: ___/___/_____

DATE OF LOSS: ___/___/_____

COLLISION INFORMATION

DATE OF COLLISION:	**TIME OF COLLISION:**	**TOTAL DAMAGES:** **$**	**VEHICLE YEAR:**	**MAKE:**	**MODEL:**

HOW MANY PEOPLE WERE IN THE VEHICLE DURING THE COLLISION?	**YOUR LOCATION IN THE VEHICLE:** ☐ Driver ☐ Passenger-Front ☐ Passenger-Rear	**ROAD CONDITIONS:** ☐ Dry ☐ Wet ☐ Dirt ☐ Icy
WERE YOU WEARING YOUR SEAT BELT? ☐ Yes ☐ No	**DID THE AIRBAGS DEPLOY?** ☐ Yes ☐ No	**IF YES, DID THE AIRBAGS HIT YOUR BODY?** ☐ Yes ☐ No Where? _____

NUMBER OF OTHER VEHICLES INVOLVED? ☐ 1 ☐ 2 ☐ 3 or More *(If 3 or More, attach additional sheets)*	**#1. VEHICLE YEAR:**	**MAKE:**	**MODEL:**
	#2. VEHICLE YEAR:	**MAKE:**	**MODEL:**
	#3. VEHICLE YEAR:	**MAKE:**	**MODEL:**

NAME OF THE STREET YOU WERE ON: **NAME OF THE NEAREST CROSS STREET:**	**NAME OF THE STREET OTHER VEHICLE(S) WERE ON:** ☐ **SAME** **NAME OF CITY WHERE COLLISION OCCURRED:**

DID THE POLICE COME TO THE SCENE? ☐ Yes ☐ No If "Yes", What department:_____	**DO YOU HAVE A POLICE REPORT?** ☐ Yes ☐ No Case Report #_____	**WHO WAS AT FAULT FOR THE COLLISION?** ☐ You ☐ Driver of Your Vehicle ☐ Driver of Other Vehicle
YOUR VEHICLE WAS: ☐ Moving ☐ Turning ☐ Stopped	**YOUR VEHICLE: (CHECK ALL THAT APPLY)** ☐ Was Hit by Another Vehicle ☐ Hit Another Vehicle ☐ Spun ☐ Rolled Over ☐ Hit a Stationary Object (Light Pole, Curb, Building, etc.)	
WHERE WAS THE IMPACT TO YOUR VEHICLE? ☐ Front ☐ Rear ☐ Driver's Side ☐ Passenger's Side	**TYPE OF COLLISION:** ☐ Head-on Collision ☐ Rear-end Collision ☐ T-Boned ☐ Side-Swiped ☐ Other: _____	
DID YOU SEE THE COLLISION COMING? ☐ Yes ☐ No	**THE OTHER VEHICLES WERE (VEHICLE #1):** ☐ Moving ☐ Turning ☐ Stopped	**VEHICLE #2:** ☐ Moving ☐ Turning ☐ Stopped

EXPLAIN HOW YOUR COLLISION OCCURED:

_____

_____

_____

_____

_____

AT THE TIME OF IMPACT, YOU WERE LOOKING: ☐ Forward ☐ Right ☐ Left ☐ Backward	**UPON IMPACT, DID ANY OF THE FOLLOWING OCCUR?** ☐ Neck Whipped Back ☐ Thrown Side to Side ☐ Ejected from Vehicle

DID YOUR BODY HIT THE INSIDE OF THE VEHICLE? ☐ Yes ☐ No If Yes, Where? _____	**DID YOU HIT YOUR HEAD?** ☐ Yes ☐ No	**IF SO, WHERE?** ☐ Steering Wheel ☐ Windshield ☐ Headrest ☐ Door

DO YOU THINK YOU LOST CONSCIOUSNESS? ☐ Yes ☐ No If Yes, How Long? _____ ☐ Sec. ☐ Min. ☐ Hours	**WERE YOU:** ☐ Shaken ☐ Disoriented ☐ Dazed If Yes, How Long? _____ ☐ Sec. ☐ Min. ☐ Hours

DID YOU RECEIVE ANY:
☐ Bruises ☐ Cuts/Lacerations/Abrasions (where:_____)

INITIALS: _____

SYNERGY HEALTH PARTNERS

PATIENT NAME: _____

TODAY'S DATE: ___/___/_____

DATE OF LOSS: ___/___/_____

TREATMENT RECEIVED AFTER THIS COLLISION

WERE YOU TREATED ON THE SCENE BY PARAMEDICS?
☐ Yes ☐ No

DID YOU GO TO THE EMERGENCY ROOM, HOSPITAL, OR URGENT CARE? ☐ Yes ☐ No (Please indicate below which hospital)

IF "YES", WHEN DID YOU GO?
☐ Day of the collision ☐ Other Date: _____/_____/_____

IF THE DAY OF THE COLLISION, HOW DID YOU GET THERE?
☐ Ambulance ☐ Self ☐ Other: _____

Hospital/Provider	Date	Hospital/ Provider	Date	Hospital/ Provider	Date
☐ Children's Hospital	__/__/__	☐ Medical Center of Aurora	__/__/__	☐ St. Anthony's Central	__/__/__
☐ Denver Health	__/__/__	☐ North Suburban Medical	__/__/__	☐ St. Joseph's Hospital	__/__/__
☐ Good Samaritan	__/__/__	☐ Porter Adventist	__/__/__	☐ Swedish Medical Center	__/__/__
☐ Kaiser Permanente	__/__/__	☐ Rose Medical Center	__/__/__	☐ University Hospital	__/__/__
☐ Littleton Adventist	__/__/__	☐ St. Anthony North	__/__/__	☐ Sky Ridge Medical	__/__/__
☐ Lutheran Med. Cent	__/__/__				

WHERE HAVE YOU GONE FOR ADDITIONAL TREATMENT SINCE THE COLLISION? (CHECK ALL THAT APPLY)

Primary Care Doctor:		**Start Date**		**Number of visits:**	
Physical Therapy:		**Start Date:**		**Number of Visits:**	
Chiropractic:		**Start Date:**		**Number of Visits:**	
Specialist:		**Start Date:**		**Number of Visits:**	
Surgery:		**Date:**		**Location:**	

WHICH OF THE FOLLOWING DIAGNOSTIC TESTS HAVE YOU HAD FOR THIS COLLISION?

	FACILITY	BODY PART	DATE	KNOWN RESULTS
☐ X-RAY	_____	_____	___/___/___	_____
☐ CT Scan	_____	_____	___/___/___	_____
☐ MRI	_____	_____	___/___/___	_____
☐ Ultrasound	_____	_____	___/___/___	_____

DID YOU HAVE A GAP/BREAK IN CARE FOR THIS COLLISION (I.E. DID NOT SEE A HEALTH CARE PROVIDER WITHIN THE FIRST FEW DAYS OR HAD A BREAK IN CARE AGAIN FOR 2 WEEKS OR MORE)?

☐ Yes ☐ No

IF "YES" TO ANY OF THE ABOVE, PLEASE CHECK THE REASON(S) FROM THE FOLLOWING LIST:

☐ I thought I would get better with time or assumed I could treat myself at home.

☐ I could not afford to pay out-of-pocket expenses for needed care.

☐ I was out of town and unable to find a provider in that area.

☐ I was afraid I would lose my job.

☐ Had to make and wait for the appointment.

☐ I have no health insurance.

☐ I ran out of health insurance benefits.

☐ I was refused treatment at the doctor's office as it was auto insurance.

☐ Insurance Company problems over treatment and/or payment.

☐ Unsure on what to do or where to go for help.

☐ Other:_____

INITIALS: _____

SYNERGY HEALTH PARTNERS

PATIENT NAME: _____

TODAY'S DATE: ___/___/_____

DATE OF LOSS: ___/___/_____

Please mark all areas of pain with the symbols below.

▽ ▽ ▽ ▽ ACHING

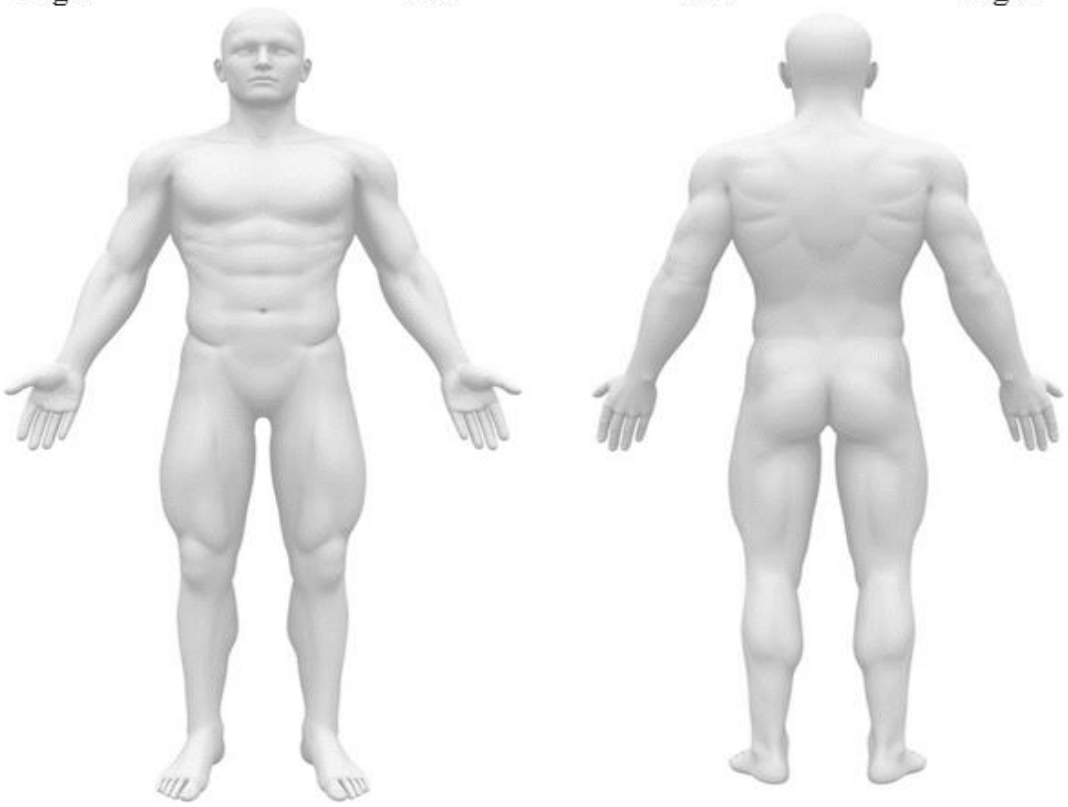
= = = = NUMBNESS

• • • • PINS & NEEDLES

X X X X BURNING

//// STABBING

Right Left Left Right



DO YOU HAVE ANY OF THE FOLLOWING:

☐ Loss of Bowel/ Bladder Function

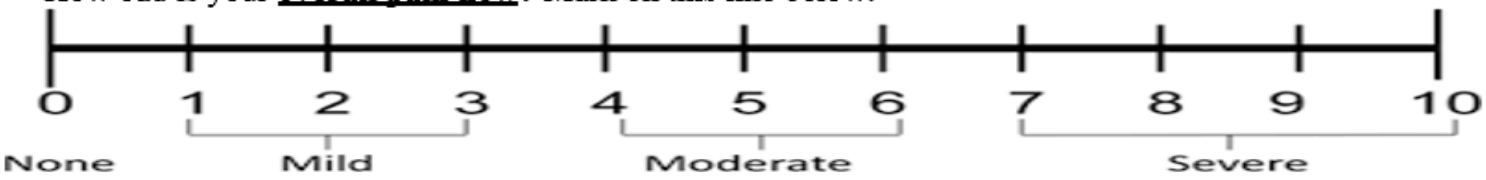
☐ Dizziness/Light Headed

☐ Vision Changes (Blurred/Double)

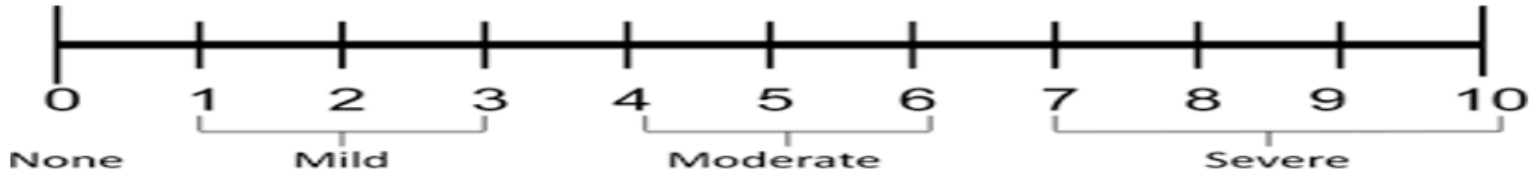
☐ Headache (Draw on person)

☐ None

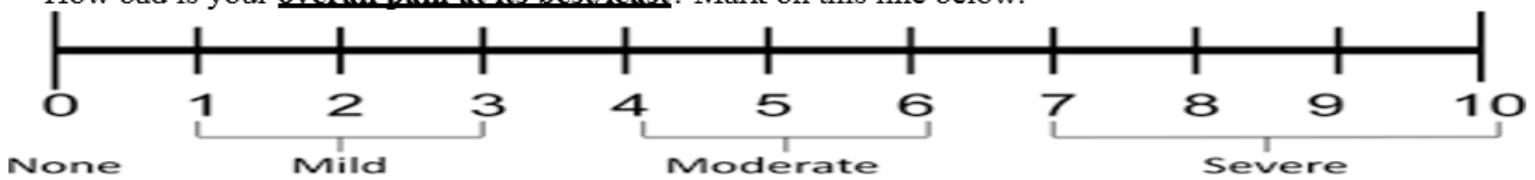
How bad is your **overall pain now**? Mark on this line below.



How bad is your **overall pain at its worst**? Mark on this line below.



How bad is your **overall pain at its best/least**? Mark on this line below.



INITIALS: _____

SYNERGY HEALTH PARTNERS

PATIENT NAME: _____

TODAY'S DATE: ___/___/_____

DATE OF LOSS: ___/___/_____

CURRENT COMPLAINTS

What are your main problems or difficulties NOW? (Check all that apply)

1. ***For each area of complaint, please provide a pain rating from the following scale:***

None	Minimal	Mild	Moderate	Severe	Most Possible

2. ***For each area of complaint, please describe the type of pain using the following descriptors:***

Achy	**Sharp**	**Shooting**
Dull	**Burning**	**Pins & Needles**
Stabbing	**Throbbing**	**Tightness**

Complaints NOW	Pain Rating (From Above)	Type of Pain	Did You Have This Complaint BEFORE the Collision?
☐ **Headaches**			☐ Yes ☐ No
☐ **Facial Pain**			☐ Yes ☐ No
☐ **Neck Pain**			☐ Yes ☐ No
☐ **Upper Back Pain**			☐ Yes ☐ No
☐ **Mid-Back Pain**			☐ Yes ☐ No
☐ **Lower Back Pain**			☐ Yes ☐ No
☐ **Buttock Pain**			☐ Yes ☐ No
☐ **Hip Pain (Left)**			☐ Yes ☐ No
☐ **Hip Pain (Right)**			☐ Yes ☐ No
☐ **Knee Pain (Left)**			☐ Yes ☐ No
☐ **Knee Pain (Right)**			☐ Yes ☐ No
☐ **Ankle Pain (Left)**			☐ Yes ☐ No
☐ **Ankle Pain (Right)**			☐ Yes ☐ No
☐ **Shoulder Pain (Left)**			☐ Yes ☐ No
☐ **Shoulder Pain (Right)**			☐ Yes ☐ No
☐ **Chest/Rib Pain**			☐ Yes ☐ No
☐ **Elbow Pain (Left)**			☐ Yes ☐ No
☐ **Elbow Pain (Right)**			☐ Yes ☐ No
☐ **Wrist / Hand Pain (Left)**			☐ Yes ☐ No
☐ **Wrist / Hand Pain (Right)**			☐ Yes ☐ No
☐ **Bowel / Bladder Dysfunction**			☐ Yes ☐ No
☐ **Dizziness / Light Headed**			☐ Yes ☐ No
☐ **Loss of Balance**			☐ Yes ☐ No
☐ **Ringing / Buzzing in the Ears**			☐ Yes ☐ No
☐ **Vision Changes** (Blurred/Double)			☐ Yes ☐ No
☐ **Loss of Smell or Taste**			☐ Yes ☐ No
☐ **Other:**			☐ Yes ☐ No
☐ **Other:**			☐ Yes ☐ No
☐ **Other:**			☐ Yes ☐ No

SYNERGY HEALTH PARTNERS

PATIENT NAME: _____

TODAY'S DATE: ___/___/_____

DATE OF LOSS: ___/___/_____

EMOTIONAL/BEHAVIORAL CHANGES

DO YOU HAVE ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY)

- ☐ Depression / Sadness
- ☐ Nightmares About Accident
- ☐ Irritable/Angry
- ☐ Discouraged / Frustrated
- ☐ Nervous/ Worried
- ☐ Problems Thinking
- ☐ Appetite Changes (Loss / Gain)
- ☐ Driving Anxiety
- ☐ Memory Loss
- ☐ Sensitive to Sound/Light/Motion
- ☐ Feeling Tired All The Time
- ☐ Other:_____

COGNITIVE CHANGES

DO YOU HAVE ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY)

- ☐ Forgetful
- ☐ Lack of Concentration
- ☐ Difficulty Understanding words or instructions
- ☐ Difficulty Problem Solving
- ☐ Slow in Thinking/Acting/Speaking
- ☐ Trouble Finding Words
- ☐ Getting Lost or Confused
- ☐ Other:_____ _____

At any time during the event, did you think you might die or not survive? ☐ Yes ☐ No

I stay away from the things that remind me of the event? ☐ Yes ☐ No

Sometimes images from the event pop into my mind even when I am not thinking about it? ☐ Yes ☐ No

WHAT INCREASES YOUR PAIN? (CHECK ALL THAT APPLY)

- ☐ Sitting
- ☐ Standing
- ☐ Bending
- ☐ Stress or Tension
- ☐ Other:_____
- ☐ Lifting
- ☐ Walking
- ☐ Work
- ☐ Coughing or Sneezing
- ☐ Lying Down
- ☐ Grasping
- ☐ Reaching
- ☐ Weather Changes

WHAT DECREASES YOUR PAIN? (CHECK ALL THAT APPLY)

- ☐ Rest
- ☐ Ice
- ☐ Physical Therapy
- ☐ Sitting
- ☐ Other:_____
- ☐ Medications
- ☐ Stretching
- ☐ Chiropractic
- ☐ Standing
- ☐ Heat
- ☐ Exercise
- ☐ Massage
- ☐ Lying Down

ACTIVITIES OF DAILY LIVING / FUNCTIONAL STATUS

(These questions are about how your symptoms/injuries affect your activities now. Check **ALL** the activities that have been limited in the last 4 weeks due to your injuries/collision.)

BASIC SELF-CARE / ACTIVITIES OF DAILY LIVING:

- ☐ Bathing / Showering
- ☐ Brushing Teeth
- ☐ Dressing
- ☐ Combing Hair
- ☐ Eating
- ☐ Sexual Activity

COMPLEX SELF-CARE AND HOUSEHOLD DUTIES:

- ☐ Meal Preparation
- ☐ Cleaning
- ☐ Financial Management
- ☐ Vacuuming
- ☐ Sweeping / Mopping
- ☐ Other: _____
- ☐ Yard Work
- ☐ Managing Medications

BASIC MOBILITY:

- ☐ Walking
- ☐ Running
- ☐ Grasping
- ☐ Squatting / Stooping
- ☐ Pushing
- ☐ Reaching
- ☐ Bending
- ☐ Sit-to-Stand
- ☐ Lifting Above Shoulder
- ☐ Lying Down
- ☐ Climbing Stairs
- ☐ Getting Up from lying down
- ☐ Driving/Riding
- ☐ Kneeling
- ☐ Lifting from Floor
- ☐ Pulling
- ☐ Moving Neck
- ☐ Other:_____

BASIC COMMUNICATION:

- ☐ Hearing
- ☐ Writing
- ☐ Speaking
- ☐ Typing
- ☐ Computer Use
- ☐ Texting

CHILDCARE ACTIVITIES: (☐ N/A, I Do Not Have Small Children)

- ☐ Lifting/Holding
- ☐ Changing Diapers
- ☐ Other: _____
- ☐ Dressing Child
- ☐ Bathing Child
- ☐ Helping w/Homework
- ☐ Car Seat Management

Number of Children: _____ **Age(s) of Children:** _____

INITIALS: _____

SYNERGY HEALTH PARTNERS

PATIENT NAME: _____

TODAY'S DATE: ___/___/_____

DATE OF LOSS: ___/___/_____

DO YOU HAVE PROBLEMS SLEEPING DUE TO YOUR PAIN?

☐ Yes ☐ No

HOW MANY HOURS OF RESTFUL SLEEP DO YOU GET PER NIGHT?

_____

DO YOU SLEEP TOO MUCH?

☐ Yes ☐ No

HOW MANY TIMES PER NIGHT DO YOU WAKE UP WITH PAIN?

_____

ARE THERE ANY HOBBIES OR RECREATIONAL ACTIVITIES YOU COULD DO PREVIOUSLY THAT YOU CANNOT DO NOW?

☐ Yes ☐ No If "Yes", what activities:

_____

MEDICAL HISTORY/ REVIEW OF SYSTEMS

CHECK ALL CURRENT AND/OR PAST MEDICAL CONDITIONS (Not related to this collision):

	CURRENT	PAST		CURRENT	PAST
HIGH BLOOD PRESSURE	☐	☐	BLOOD/ANEMIA/BRUISING	☐	☐
HEAD/ HEADACHES	☐	☐	BONES/ JOINTS	☐	☐
HEART DISEASE/ CIRCULATION	☐	☐	EYES/VISION	☐	☐
DEPRESSION/ANXIETY/BIPOLAR	☐	☐	DIABETES	☐	☐
COPD/LUNGS/ASTHMA	☐	☐	KIDNEY DISEASE	☐	☐
THYROID DISEASE	☐	☐	OSTEOPOROSIS	☐	☐
SLEEP APNEA/SLEEPING	☐	☐	PREGNANCY	☐	☐
HIGH CHOLESTEROL	☐	☐	CANCER	☐	☐
AIDS/HIV POSITIVE	☐	☐	STOMACH/BOWELS	☐	☐
LIVER DISEASE	☐	☐	FEMALE PARTS	☐	☐
SEIZURES/EPILEPSY	☐	☐	MALE PARTS	☐	☐
EARS/HEARING	☐	☐	BRAIN	☐	☐
OTHER:_____				☐	☐

HAVE YOU EVER HAD ANY SURGERIES/HOSPITALIZATIONS? ☐ Yes ☐ No If "Yes", please list:

TYPE OF SURGERY / WHY HOSPITALIZED	YEAR	FULLY RECOVERED?
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

EVER BEEN IN AN AUTO COLLISION BEFORE?

☐ Yes ☐ No

IF "YES", HOW MANY? _____

WHEN? _____

DID YOU COMPLETELY RECOVER?

☐ Yes ☐ No

IF YOU DID NOT COMPLETELY RECOVER, WHAT ARE THE RESIDUAL COMPLAINTS? (☐ N/A)

_____

EVER HAD A WORK-RELATED INJURY?

☐ Yes ☐ No

IF "YES", HOW MANY? _____

WHEN? _____

DID YOU COMPLETELY RECOVER?

☐ Yes ☐ No

IF YOU DID NOT COMPLETELY RECOVER, WHAT ARE THE RESIDUAL COMPLAINTS? (☐ N/A)

_____

INITIALS: _____

SYNERGY HEALTH PARTNERS

PATIENT NAME: _____

TODAY'S DATE: ___/___/_____

DATE OF LOSS: ___/___/_____

ARE YOU ALLERGIC TO ANY MEDICATIONS?
☐ Yes ☐ No
If "Yes", Explain: _____

ARE YOU ALLERGIC TO LATEX?
☐ Yes ☐ No

ARE YOU ALLERGIC TO MEDICAL TAPES?
☐ Yes ☐ No

DO YOU USE THE FOLLOWING? ☐ Cane ☐ Walker ☐ Crutches ☐ Wheelchair **IF SO, HOW LONG?**_____

MEDICATIONS

Please list **ALL PRESCRIPTION** medications that you are **CURRENTLY** taking:

MEDICATION	DOSE	HOW OFTEN?	WHEN STARTED?	WHY?

Please list **ALL OVER-THE-COUNTER** medications that you are **CURRENTLY** taking:

MEDICATION	DOSE	HOW OFTEN?	WHEN STARTED?	WHY?

FAMILY MEDICAL HISTORY (Examples: Diabetes, High Blood Pressure, Cancer, etc.)

Mother: _____
Father: _____
Siblings/ Other Releatives: _____

OCCUPATION / WORK HISTORY

(The purpose of this section is to understand how your injuries have affected your work.)

CURRENT EMPLOYER:	JOB TITLE / OCCUPATION:
JOB DUTIES AND RESPONSIBILITIES:	

WHAT ARE THE PHYSICAL REQUIREMENTS OF YOUR JOB? (CHECK ALL THAT APPLY)

☐ Sitting ☐ Standing ☐ Typing ☐ Bending
☐ Squatting ☐ Kneeling ☐ Climbing (Ladders, etc.) ☐ Lifting (_____ lbs.)

HAVE YOU MISSED ANY TIME FROM WORK DUE TO THIS COLLISION? ☐ Yes ☐ No ☐ I have not returned to work

IF YES, HOW MANY HOURS OR DAYS HAVE YOU MISSED? _____

IF YOU ARE CURRENTLY WORKING, ARE YOU MODIFYING YOUR HOURS OR DUTIES? (CHECK ALL THAT APPLY):

☐ Normal Hours ☐ Decreased Hours ☐ Normal Job Duties ☐ Modified Job Duties ☐ Different Jobs

If you are working a different job since the collision, please explain: _____

INITIALS: _____

SYNERGY HEALTH PARTNERS

PATIENT NAME: _____

TODAY'S DATE: ___/___/_____

DATE OF LOSS: ___/___/_____

SOCIAL HISTORY

DO YOU SMOKE/USE TOBACCO?
☐ Yes ☐ No

IF "YES", HOW OFTEN?
_____ / ☐ Day ☐ Week ☐ Month

DO YOU DRINK ALCOHOL?
☐ Yes ☐ No

IF "YES", HOW OFTEN?
_____ / ☐ Day ☐ Week ☐ Month

DO YOU USE ILLEGAL DRUGS?
☐ Yes ☐ No

WHAT IS THE HIGHEST EDUCATION LEVEL YOU HAVE COMPLETED?
☐ Elementary ☐ High School ☐ Vocational ☐ Some College ☐ College Degree ☐ Advanced Degree ☐ Other: _____

PATIENT AFFIRMATION:

By signing below, you confirm that the information you provided is accurate to the best of your knowledge.

Patient's Signature: _____ **Date:** _____/_____/_____

Parent / Guardian Signature ***(If patient is a minor):*** _____ **Date:** _____/_____/_____

Photo Permission: ***I give my permission to take my photo for the purposes of chart identification and, if necessary, to document portions of the physical exam.***

Patient's Signature: _____ **Date:** _____/_____/_____

If filled out by a person other than the patient, please provide name and signature below.

Printed Name: _____ **Signature:** _____

INITIALS: _____