Welcome to Blum-Nico Oral Surgery Associates www.BlumNico.com

Miami Beach 4308 Alton Rd. #850, Miami Beach, Fl 33140 T: (305) 538-4556

<u>Aventura</u> 2999 N.E. 191 St. #607, Aventura, FI 33180 T: (305) 936-5974

| Patient's Name: (Mr., Mrs., Ms., Dr.) | | | | Today's Date: | | | | | |
|--|--|---|-----------------------------|---|---|-------------------|----------------|--|--|
| | | 1 | | | | one: | | | |
| | rital Status: Single Married Divorce | | | C | ontact Person (not living with you) Ph | one: | | | |
| Age: Birthdate: Sex: Male Female | | | | Who is responsible for this account? | | | | | |
| HOI | ne Phone: | | | | | | | | |
| | rk Phone:Cell Phone: | | | P | atient/Parent employed by: | | | | |
| E-mail: | | | | Employer's address: Phone: | | | | | |
| | w would you like us to confirm your appointmephone Email Text Message | ent? | | L | imployer's address: | one: | | | |
| | | | | $\overline{\mathbf{N}}$ | Iedical Insurance Coverage Information: | | | | |
| DIT | ver's Lic/S.S. #: | | | Insured's Name: | | | | | |
| Auc | dress: | | | Insured's Name: Date of Birth: Social Sec. No. Name of Insurance Co. | | | | | |
| | y:State:Zip: | | | 1 | value of filsurance Co. | | | | |
| | sent Complain: | | | | lan/ID No.:ental Insurance Coverage: | | | | |
| wn | o referred you to this office? | | | <u>ע</u> Ir | isured's Name: | | | | |
| | ··· · DI | | | D | nsured's Name: Social Sec. No | | | | |
| Den | tist: Phone: | | | Name of Insurance Co. | | | | | |
| | n | | | Plan/ID No.: | | | | | |
| Phy | rsician: Phone: | | | \mathbf{N} | Iethod of Payment: | | | | |
| | | | | Ir | nsurance Credit Card Cash/Check O | ther | - | | |
| 1 A | are you in good health? | | | | | Vac | No | | |
| | Ias there been any change in your general health | | | | | | No | | |
| 7 H | | | | | | | No | | |
| | | | | | | | | | |
| 3. A | are you under the care of a physician? f yes, for what? | | | | | | | | |
| 3. A I 4.H | are you under the care of a physician?f yes, for what?ave you had any illnesses, operations or hospitali | | | | Date of last Visit: | | No | | |
| 3. A I 4.H | are you under the care of a physician?f yes, for what?ave you had any illnesses, operations or hospitalif yes, describe: | zations | ? | | Date of last Visit:_ | Yes | | | |
| 3. A I 4.H I 5a. | are you under the care of a physician?f yes, for what? ave you had any illnesses, operations or hospitalif yes, describe: Have you ever been told that you need to premed | zations | ?efore a | ny de | Date of last Visit:_ | Yes | | | |
| 3. A I 4.H I 5a. 5b. | are you under the care of a physician?f yes, for what?ave you had any illnesses, operations or hospitalif yes, describe:Have you ever been told that you need to premed Have you ever or do you currently take medication. | zations licate be | ?efore an | ny de | Date of last Visit: ental treatment? nt of osteoporosis? | Yes | No | | |
| 3. A I 4.H I 5a. 5b. | are you under the care of a physician?f yes, for what? ave you had any illnesses, operations or hospitalif yes, describe: Have you ever been told that you need to premed | zations licate be | ?efore an | ny de | Date of last Visit: ental treatment? nt of osteoporosis? | Yes | No | | |
| 3. A I 4.H I 5a. 5b. | are you under the care of a physician?f yes, for what? ave you had any illnesses, operations or hospitalif yes, describe: Have you ever been told that you need to premed Have you ever or do you currently take medication. For example Zometa, Reclast, Boniva, Actonel, Reclast, Boniva, Actonel, Reclast, Boniva, Actonel, Reclast, Boniva, Reclast, Boniva, Reclast, Boniva, Reclast, Boniva, Reclast, Boniva, Reclast, Boniva, Boniva, Reclast, Boniva, | izations licate be ons for Prolia, 2 | ?efore and the treat | ny de itmen | ental treatment? | Yes | No No | | |
| 3. A I 4.H I 5a. 5b. | are you under the care of a physician? | zations licate be ons for Prolia, 2 | ?efore and the treat Xgeva, | ny de itmen | ental treatment? | Yes | No No | | |
| 3. A I 4.H I 5a. 5b. | are you under the care of a physician? f yes, for what? ave you had any illnesses, operations or hospitalif yes, describe: Have you ever been told that you need to premed Have you ever or do you currently take medication for example Zometa, Reclast, Boniva, Actonel, Fease Answer all Questions by Che HAVE YOU HAD OR DO YOU CURRENTLY | izations licate be ons for Prolia, 2 | ?efore and the treat | ny de itmen | ental treatment? | Yes | No No | | |
| 3. A I 4.Ha 5a. 1 5b. 1 | are you under the care of a physician? | zations licate be ons for Prolia, 2 | ?efore and the treat Xgeva, | ny dentmen Even | ental treatment? nt of osteoporosis? nity, Alendronate, Fosamax NO All answers are kept confidential HAVE YOU HAD OR DO YOU CURRENTLY HAVE | Yes Yes Yes | No No No | | |
| 3. A I 4.Ha 5a. 1 5b. 1 | Are you under the care of a physician? | zations licate be ons for Prolia, 2 | ?efore and the treat Xgeva, | ny de itmen | nt of osteoporosis? nty, Alendronate, Fosamax | Yes Yes Yes | No No No | | |
| 3. A I 4.H I 5a | are you under the care of a physician? f yes, for what? ave you had any illnesses, operations or hospitalif yes, describe: Have you ever been told that you need to premed Have you ever or do you currently take medication for example Zometa, Reclast, Boniva, Actonel, Fease Answer all Questions by Che Have you Had or Do You Currently Have Rheumatic fever? Congenital heart disease? | zations licate be ons for Prolia, 2 | ?efore and the treat Xgeva, | ny dentrone | ntal treatment? | Yes Yes Yes | No No No | | |
| 3. A I 4.H I 5a | are you under the care of a physician? f yes, for what? ave you had any illnesses, operations or hospitalif yes, describe: Have you ever been told that you need to premed Have you ever or do you currently take medication for example Zometa, Reclast, Boniva, Actonel, For example Zometa, Reclast, Boniva, Boniva, Reclast, Boniva, Boniva, Boniva, Reclast, Boniva, Boni | zations licate be ons for Prolia, 2 | ?efore and the treat Xgeva, | or o | ntal treatment? | Yes Yes Yes | No No No | | |
| 3. A I 4.H I 5a | are you under the care of a physician? f yes, for what? ave you had any illnesses, operations or hospitalif yes, describe: Have you ever been told that you need to premed Have you ever or do you currently take medication for example Zometa, Reclast, Boniva, Actonel, For example Zometa, Reclast, Boniva, Boniva, Reclast, Boniva, Boniva, Reclast, Boniva, B | zations licate be ons for Prolia, 2 | ?efore and the treat Xgeva, | ny dentrone | ntal treatment? | Yes Yes Yes | No No No | | |
| 3. A I 4.H I 5a | Are you under the care of a physician? | zations licate be ons for Prolia, 2 | ?efore and the treat Xgeva, | or o | ntal treatment? | Yes Yes Yes | No No No | | |
| 3. A I I 4.H. I 5a | Are you under the care of a physician? | zations licate be ons for Prolia, 2 | ?efore and the treat Xgeva, | OR 14. 15. 16. 17. | ental treatment? | Yes Yes Yes | No No No | | |
| 3. A I 4.H I 5a. 5b. | Are you under the care of a physician? | zations licate be ons for Prolia, 2 | ?efore and the treat Xgeva, | OR 14. 15. 16. 17. | ntal treatment? | Yes Yes Yes | No No No | | |
| 3. A I I 4.H. I 5a | Are you under the care of a physician? | zations licate be ons for Prolia, 2 | ?efore and the treat Xgeva, | OR 14. 15. 16. 17. 18. | ntal treatment? | Yes Yes Yes | No No No | | |
| 3. A I I 4.H. I 5a | Are you under the care of a physician? | zations licate be ons for Prolia, 2 | ?efore and the treat Xgeva, | OR 14. 15. 16. 17. 18. 19. | ntal treatment? | Yes Yes Yes | No No No | | |
| 3. A I I 4.H. I 5a | Are you under the care of a physician? | zations licate be ons for Prolia, 2 | ?efore and the treat Xgeva, | OR 14. 15. 16. 17. 18. | ntal treatment? | Yes Yes Yes | No No No | | |
| 3. A I I 4.H. I 5a | Are you under the care of a physician? | zations licate be ons for Prolia, 2 | ?efore and the treat Xgeva, | ny de atmer Even OR 14. 15. 16. 17. 18. 19. 20. 21. | ntal treatment? | Yes Yes Yes | No No No | | |
| 3. A I I 4.H. I 55a. I 5b. I PLI 6. 7. 8. 9. | Are you under the care of a physician? | zations licate be ons for Prolia, 2 | ?efore and the treat Xgeva, | OR 14. 15. 16. 17. 18. 19. | ntal treatment? | Yes Yes Yes | No No No | | |
| 3. A I I 4.H I 5a | re you under the care of a physician? | zations licate be ons for Prolia, 2 | ?efore and the treat Xgeva, | ny de atmer Even OR 14. 15. 16. 17. 18. 19. 20. 21. | ntal treatment? | Yes Yes Yes | No No No | | |
| 3. A I I 4.H I 5a | re you under the care of a physician? | zations licate be ons for Prolia, 2 | ?efore and the treat Xgeva, | ny de atmer Even OR 14. 15. 16. 17. 18. 19. 20. 21. 22. | ntal treatment? | Yes Yes Yes | No No No | | |
| 3. A I I 4.H. I 5a | re you under the care of a physician? | zations licate be ons for Prolia, 2 | ?efore and the treat Xgeva, | ny de atmer Even OR 14. 15. 16. 17. 18. 19. 20. 21. 22. | ntal treatment? nt of osteoporosis? nty, Alendronate, Fosamax | Yes Yes Yes | No No No | | |

| 26. A removable dental appliance? 30. Do you have any obteding disorders? If yes, please specify | | | YES | NO | | | YES | NO |
|--|-----------------------------------|---|---|--|---|--|--|---|
| 28. A history of Alcohol, cocaine, marijuana or others? 29. Malignant hyperthermia? 20. Date 20. Da | 26. | A removable dental appliance? | | | 30. | | | |
| 29. Malignant hyperthermia? I understand the importance of providing a truthful health history to assist my doctor in providing the best care possible. I have had the opportunity of discuss my health history with my doctor and the information I have provided here is complete and accurate. Patient/Guardian's Signature Date FOR WOMEN ONLY. A. If you are using oral contracespives it is important that you understand that arribibities and other medications may interfare with the effectiveness of antibibities or other medications a complete opice of birth control pills after the course of antibibities or other medications as completed Please consult why and physician for their guidance. B. If you are pregnant, possibly pregnant, or trying to become pregnant, surgery, anesthetics or any other medication may significantly harm your developing buby, especially during the first interest. Please advise your doctor if there is any chance of your being pregnant. 1 Are you pregnand or planning pregnancy? 2 Are you taking no bring pregnancy? 2 Are you taking hormone replacements? CONSENT AND RELEASE OF RECORDS The information, both on this page and on the medical history, are correct to the best of my knowledge. I authorize the doctors from Blum-Nice Oral Fucial Surgery Associates and their designated stuff, to perform a moral and mustiloidicated examination and take x-rays as required for the purpose of diagnosis and treatment planning. Furthermore. I authorize the release of any records from my medical doctor, dentist, or specialist needed for diagnosis and treatment. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment. CONSENT TO USE RECORDS Thereby give permission for the use records including photographs taken during the examination(s), treatment, and retention for the purposes or professional consultations, research, education, or publication in professional journals. I consent to the taking of photographs(s) and video(s) of | 27. | Pain and clicking of jaws when eating? | | | 31. | problem that the doctor should know about? | | |
| I understand the importance of providing a truthful health history to assist my doctor in providing the best care possible. I have had the opportunity of issuess my health history with my doctor and the information I have provided here is complete and accurate. Patient/Guardian's Signature Date Patient/Guardian's Signature | 28. | A history of Alcohol, cocaine, marijuana or others? | | | 32. | Do you wish to talk with the doctor privately about anything? | | |
| Patient/Guardian's Signature Date FOR WOMEN ONLY A. If you are using and contraceptives it is important that you understand that antibiotics and other medications may interfere with the effectiveness of antibiotics or other medications is completed. Pleases consult with your physician for further guidance. B. If you are pregnant, possebby pregnant or trying to become pregnant, surgery, ensethetics or any other medication may significantly harm your developing baby, especially during the first trimester. Please advise your doctor if there is any chance of your being pregnant. 1. Are you pregnant or planning pregnancy? Yes No 3. Are you taking hormone replacements? CONSENT AND RELEASE OF RECORDS The information, both on this page and on the medical history, are correct to the best of my knowledge. I authorize the doctors from Blum-Nice Oral Facial Surgery Associates and their designated staff, to perform an oral and maxillofacial examination and take x-rays as required for the purpose of diagnosis and treatment planning. Furthermore, lauthorize the release of any information acquired in the course of my examination and treatment. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment. CONSENT TO USE RECORDS Thereby give permission for the use records including photographs taken during the examinations, the treatment, and retention for the purposes of professional consultations, research, education, or publication in professional journals. I consent to the taking of photograph(s) and video(s) of the undersigned which may be reproduced and/or used in any and all advertisement or promotional purposes for the above doctor(s) and practice, including but not limited to websites, Facebook, Twitter, and others oscial media. In giving this consent, I release the above practice and doctor(s) from liability for any violation of any personal or proprietary right I may have in connection with such photograph/video reproduction or use. F | 29. | Malignant hyperthermia? | | | | | | |
| FOR WOMEN ONLY A. If you are using oral contraceptives it is important that you understand that antibiotics and other medications may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills after the course of antibiotics or other medications so completed. Please consult with your physician for further guidance. B. If you are pregnant, possibly pregnant, or trying to become pregnant, surgery, anessthetics or any other medication may significantly harm your developing baby, especially during the first timester. Please advise your doctor if there is any chance of your being pregnant. 1. Are you pregnant or planning pregnancy? 2. Are you taking any birth control pills? 3. Are you taking any birth control pills? CONSENT AND RELEASE OF RECORDS The information, both on this page and on the medical history, are correct to the best of my knowledge. I authorize the doctors from Blum-Nicc Oral Facial Surgery Associates and their designated staff, to perform an oral and maxillofacial examination and take x-rays as required for the purpose of diagnosis and treatment, In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment. CONSENT TO USE RECORDS I hereby give permission for the use records including photographs taken during the examination(s), treatment, and etention for the purposes o professional consultations, research, education, or publication in professional journals. I consent to the taking of photograph(s) and video(s) of the undersigned which may be reproduced and/or used in any and all advertisement or promotional purposes for the above doctor(s) and practice, including but not limited to websites, Facebook, Twitter, and other social media. In giving this consent, I release the above practice and doctor(s) from liability for any violation of any personal or proprietary right I may have in connection with such photog | | | | | | | ne oppor | tunity to |
| A. If you are using oral contraceptives it is important that you understand that antibiotics and other medications may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of brith control for one complete cycle to brith control pills after the course of antibiotics or other medications is completed. Please consult with your physician for further guidance. 8. If you are pregnant, possibly pregnant, or trying to become pregnant, surgery, anesthetics or any other medication may significantly harm your developing baby, especially during the first trimester. Please advise your doctor if there is any chance of your being pregnant. 1.Are you pregnant or planning pregnancy? Yes No 3.Are you taking any pitch control pills? CONSENT AND RELEASE OF RECORDS The information, both on this page and on the medical history, are correct to the best of my knowledge. I authorize the doctors from Blum-Nico Oral Facial Surgery Associates and their designated staff, to perform an oral and maxillofacial examination and take x-rays as required for the purpose of diagnosis and treatment planning. Furthermore, I authorize the release of any records from my metal guidage and the course of my examination and treatment. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment. CONSENT TO USE RECORDS I hereby give permission for the use records including photographs taken during the examination(s), treatment, and retention for the purposes o professional consultations, research, education, or publication in professional journals. I consent to the taking of photograph(s) and video(s) of the undersigned which may be reproduced and/or used in any and all advertisement or promotional purposes for the above doctor(s) and practice, including but not limited to websites, Facebook, Twitter, and other social media. In giving this consent, I release the above practice and doctor(s) from liability for any violation o | Patio | ent/Guardian's Signature | | | _Date | <u> </u> | | |
| CONSENT AND RELEASE OF RECORDS The information, both on this page and on the medical history, are correct to the best of my knowledge. I authorize the doctors from Blum-Nicc Oral Facial Surgery Associates and their designated staff, to perform an oral and maxillofacial examination and take x-rays as required for the purpose of diagnosis and treatment planning. Furthermore, I authorize the release of any records from my medical doctor, dentist, or specialist needed for diagnosis and treatment. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment. CONSENT TO USE RECORDS I hereby give permission for the use records including photographs taken during the examination(s), treatment, and retention for the purposes o professional consultations, research, education, or publication in professional journals. I consent to the taking of photograph(s) and video(s) of the undersigned which may be reproduced and/or used in any and all advertisement or promotional purposes for the above doctor(s) and practice, including but not limited to websites, Facebook, Twitter, and other social media. In giving this const. I release the above practice and doctor(s) from liability for any violation of any personal or proprietary right I may have in connection with such photograph/video reproduction or use. FEES AND PAYMENTS Thank you for choosing our office for your oral surgery care. Any fees or payments are due the date of service. Payment arrangements can be made depending on special circumstances at the discretion of our office. An estimate of the charge for any surgical procedure can be given upon request. A finance charge (18% annually) will be added to any balance over 30 days. I further agree that I will be responsible for all collections cost attorney's fees and court costs. Please remember that insurance is considered a method of reimbursing the patient for fees paid to doctor and is not a substitute for payment. Some companies pay fixed allowa | | oral contraceptives. Therefore, you will need to use antibiotics or other medications s completed. Please If you are pregnant, possibly pregnant, or trying to be developing baby, especially during the first trimeste 1. Are you pregnant or planning pregnancy? | mechan e consult become p r. Please | ical form t with your pregnant e advise | ns of b ur phy t, surg your d | irth control for one complete cycle of birth control pills after sician for further guidance. ery, anesthetics or any other medication may significantly loctor if there is any chance of your being pregnant. | the cours harm you Yes Yes | se of r s No s No |
| The information, both on this page and on the medical history, are correct to the best of my knowledge. I authorize the doctors from Blum-Nico Oral Facial Surgery Associates and their designated staff, to perform an oral and maxillofacial examination and take x-rays as required for the purpose of diagnosis and treatment planning. Furthermore, I authorize the release of any records from my medical doctor, dentist, or specialist needed for diagnosis and treatment. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment. **CONSENT TO USE RECORDS** I hereby give permission for the use records including photographs taken during the examination(s), treatment, and retention for the purposes o professional consultations, research, education, or publication in professional journals. I consent to the taking of photograph(s) and video(s) of the undersigned which may be reproduced and/or used in any and all advertisement or promotional purposes for the above doctor(s) and practice, including but not limited to websites, Facebook, Twitter, and other social media. In giving this consent, I release the above practice and doctor(s) from liability for any violation of any personal or proprietary right I may have in connection with such photograph/video reproduction or use. **FEES AND PAYMENTS** Thank you for choosing our office for your oral surgery care. Any fees or payments are due the date of service. Payment arrangements can be made depending on special circumstances at the discretion of our office. An estimate of the charge for any surgical procedure can be given upon request. A finance charge (18% annually) will be added to any balance over 30 days. I further agree that I will be responsible for all collections coest attorney's fees and court costs. Please remember that insurance is considered a method of reimbursing the patient for fees paid to doctor and is not a substitute for payment. Some companies pay fixed allowances for certain proc | | , , , | | | | | | |
| undersigned which may be reproduced and/or used in any and all advertisement or promotional purposes for the above doctor(s) and practice, including but not limited to websites, Facebook, Twitter, and other social media. In giving this consent, I release the above practice and doctor(s) from liability for any violation of any personal or proprietary right I may have in connection with such photograph/video reproduction or use. FEES AND PAYMENTS Thank you for choosing our office for your oral surgery care. Any fees or payments are due the date of service. Payment arrangements can be made depending on special circumstances at the discretion of our office. An estimate of the charge for any surgical procedure can be given upon request. A finance charge (18% annually) will be added to any balance over 30 days. I further agree that I will be responsible for all collections costs attorney's fees and court costs. Please remember that insurance is considered a method of reimbursing the patient for fees paid to doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures while others pay a percentage of the charge. If you have any dental and/or medical insurance we will be glad to fill out the proper forms you. Please complete the identifying information on this form. The signature below on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to the doctor named in the benefits, or otherwise payable to me. Signature: | purp need exar | Facial Surgery Associates and their designated staff, tose of diagnosis and treatment planning. Furthermore, led for diagnosis and treatment. In addition, if medical mination and treatment. CO I hereby give permission for the use records including | to perform, I authorally necessity of the photog | rm an or rize the ssary, I a NT TO graphs ta | ral and release author USE | d maxillofacial examination and take x-rays as require se of any records from my medical doctor, dentist, or rize the release of any information acquired in the count according to the examination (s), treatment, and retention for | ed for the specialis rse of my | e st y poses of |
| Thank you for choosing our office for your oral surgery care. Any fees or payments are due the date of service. Payment arrangements can be made depending on special circumstances at the discretion of our office. An estimate of the charge for any surgical procedure can be given upon request. A finance charge (18% annually) will be added to any balance over 30 days. I further agree that I will be responsible for all collections costs attorney's fees and court costs. Please remember that insurance is considered a method of reimbursing the patient for fees paid to doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures while others pay a percentage of the charge. If you have any dental and/or medical insurance we will be glad to fill out the proper forms you. Please complete the identifying information on this form. The signature below on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to the doctor named in the benefits, or otherwise payable to me. Signature: Date: | unde inclu | ersigned which may be reproduced and/or used in any ading but not limited to websites, Facebook, Twitter, a | and all a | advertis r social | ement media | or promotional purposes for the above doctor(s) and a. In giving this consent, I release the above practice a | practice, nd docto | or(s) |
| made depending on special circumstances at the discretion of our office. An estimate of the charge for any surgical procedure can be given upon request. A finance charge (18% annually) will be added to any balance over 30 days. I further agree that I will be responsible for all collections costs attorney's fees and court costs. Please remember that insurance is considered a method of reimbursing the patient for fees paid to doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures while others pay a percentage of the charge. If you have any dental and/or medical insurance we will be glad to fill out the proper forms you. Please complete the identifying information on this form. The signature below on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to the doctor named in the benefits, or otherwise payable to me. Signature: Date: | | | FEES | SAND | PAY | YMENTS | | |
| | requattor subs dent sign | e depending on special circumstances at the discretion est. A finance charge (18% annually) will be added to ney's fees and court costs. Please remember that insurtitute for payment. Some companies pay fixed allowar al and/or medical insurance we will be glad to fill out ature below on file is my authorization for the release | of our of any bal- rance is onces for the prop | office. A ance ov conside certain per form | An est er 30 red a proce is you | imate of the charge for any surgical procedure can be days. I further agree that I will be responsible for all omethod of reimbursing the patient for fees paid to docures while others pay a percentage of the charge. If you Please complete the identifying information on this | given up collection ctor and i you have form. Th | oon ns costs is not a any e |
| Witness:Date: | Sign | ature: | | | | | | |
| | Witı | ness: | | | | Date: | | |

__Date: __

Doctor's Signature: ___