New Patient Information

Full Name: _____ DOB: _____

Street Address: _____ City: _____

State: _____ Zip Code: _____ Email: _____

SSN: _____-_____-_____ Phone#: ( ) _____-_____ Secondary: ( ) _____-_____

Primary Insurance

Insurance Company: _____ Member ID#: _____

Policy Holder's Name: _____ DOB: _____ SSN: _____-_____-_____

Address: _____City: _____ State: _____ Zip Code: _____

Secondary Insurance

Insurance Company: _____ Member ID#: _____

Policy Holder's Name: _____ DOB: _____ SSN: _____-_____-_____

Address: _____City: _____ State: _____ Zip Code: _____

Emergency Contact

Name: _____ Relationship: _____

Phone #: ( ) _____-_____ Secondary: ( ) _____-_____

Pharmacy Preference

Name of Pharmacy: _____ Phone#: ( ) _____-_____

Address: _____City: _____ State: _____ Zip Code: _____

Prescription Request Policy

- All request for prescription refills must be called into your pharmacy.
- If there are no remaining refills, the pharmacy should contact our office directly.
- All requests will be addressed within 3-4 business days.
- Please note that multiple messages are not necessary and may cause a delay in your request.

Please plan ahead for your prescription refills

By signing below, you acknowledge that you have read and understand the Allen Family Medicine Prescription Request Policy:

Patient Name (Printed): _____ DOB: _____

Patient Signature: _____ Date: _____

Allen Family Medicine-7233 E. Baseline Rd., Ste. 126, Mesa, AZ 85209
Phone: 480-699-2222 Fax: 480-699-3033

Patient Voice Message Agreement

Patient Name: _____ DOB: _____

Home Phone: (____) _____-_____ Cell Phone: (____) _____-_____

Email: _____ (Please provider your email if you would like access to our patient portal)

- ☐ I give permission to Allen Family Medicine to leave EXTENDED messages when I do not answer phone calls.
- ☐ I give permission to Allen Family Medicine to leave BRIEF messages when I do not answer phone calls.
- ☐ I do NOT give Allen Family Medicine permission to leave any messages on my voicemail.

Signature: _____ Date: _____

Disclaimer: If patient agrees to Allen Family Medicine leaving any kind of message on any phone it will be the patient's responsibility to update Allen Family Medicine on any changes made to phone numbers. Allen Family Medicine is not responsible for messages left on a phone that has not been updated in the Allen Family Medicine records.

Lab Order Request Policy

When calling to request a lab work order to be reprinted, Allen Family Medicine requires a call at least **24 hours prior** to arriving to pick up the lab work order. This Policy allows the office to have the lab work order ready for you, as well as prevents taking time away from patients with appointments.

Labs are drawn by the lab company you choose to use; any payments for lab work done will be billed by the lab company you choose to use. Allen Family Medicine IS NOT responsible for any payments that your insurance doesn't cover. It is the patient's responsibility to work with the lab company to figure out what the patient owes the lab company.

Signature: _____ Date: _____

Financial Policy

Allen Family Medicine-7233 E. Baseline Rd., Ste. 126, Mesa, AZ 85209
Phone: 480-699-2222 Fax: 480-699-3033

Allen Family Medicine believes that communicating our financial policy is good healthcare practice. Charges incurred for services rendered are the patient's responsibility regardless of insurance coverage. Your insurance coverage is a contract between you and your insurance company, not your insurance company and us. It is the patient's responsibility to know your insurance benefits. We will file your primary and secondary insurances as a courtesy. Please realize that having secondary insurance does not necessarily mean that your services are covered 100%. Secondary insurances typically pay according to a coordination of benefits with the primary insurance. It is your responsibility to provide us with accurate insurance information and to inform us of any changes in your coverage as they occur.

You are responsible for all copays, coinsurance, deductibles, and non-covered services. We are required to collect your copay/deductible at the time of service per your insurance company. We accept cash, debit card, check, MasterCard & Visa. Statements are sent out weekly, and we ask that balances due be paid when you receive your statement or at your next appointment, whichever is sooner. Patient payments are typically applied to the oldest balances first, except for copayments and coinsurances- they are applied to the current date of service. Balances not paid within 90 days will be turned over to an outside collection agency, unless prior payment arrangements have been made. A 25% service fee will be added to any outstanding balance sent to an outside collection agency.

Completing FMLA forms and other requested supplemental insurance forms requires time away from patient care and day to day business operations. Payment of $75.00 is required at the time of service. Please understand that in order to complete forms your medical record must be reviewed, forms completed and signed by the physician and copied into your medical record. Some of these forms can be quite complicated and tedious to fill out. Please provide us with pertinent information, especially dates of disability and return to work. We request that you allow 5 business days for this process.

Name: _____Date: _____

Signature: _____

Financial Policy Definitions and Details

Allen Family Medicine-7233 E. Baseline Rd., Ste. 126, Mesa, AZ 85209
Phone: 480-699-2222 Fax: 480-699-3033

Allen Family Medicine is dedicated to providing medical care of the highest quality, to all of our patients, with trust and mutual respect in a caring atmosphere.

Your complete understanding of your financial responsibilities is essential; it takes a team, including patient participation, to succeed with insurance processing and reimbursement. As a courtesy, Allen Family Medicine verifies your benefits with your insurance company. A quote of benefits is not a guarantee of benefits or payment. Your claim will process according to your plan, if your claim processes differently from the benefits we were quoted, the insurance company will side with the plan and will not honor the benefit quote we received. If your insurance company fails to pay the claim, the balance will be transferred to the patient for payment.

It has become increasingly difficult to collect fees rightfully due to the provider for services rendered in good faith to their patients. Due to this, we have found it necessary to be very explicit in the financial policies of this practice. It is the policy of Allen Family Medicine that payment is due at the time of service. We require all patients to pay their deductible, copay and/or coinsurance payment at the beginning of each visit. At the conclusion of your visits with us you may be billed for any outstanding balances. If there is a credit, you will be provided a refund promptly.

Often we find patients presenting to the office with no form of payment for the services they are about to receive. We ask that when you come to our office, you have the means for payment to meet your obligations to your insurance company and to you healthcare provider.

We thank you in advance for taking the time to review these policies and your understanding of our need to have such an in depth policy.

<u>Things to bring with you to your visit</u>

- Current Health Insurance Card-We are required to verify your identity with a government approved form of ID
- Driver's License/Government approved photo ID
- Method of payment-for your convenience we accept cash, debit card, Visa, MasterCard and checks (we DO NOT accept starter check or checks from new patients)

Assignment of Benefits

Allen Family Medicine will only bill contracted insurance plans as a courtesy to our patients provided that the patient has provided the required insurance information in a timely manner and has signed a current financial policy.

Appointment cancellation, rescheduling and no shows

If you do not show for your appointment, arrive 15 minutes after your appointment time, cancel or reschedule within 24 hours of your appointment time, we will bill you an administrative "no show" fee of $35.00. Three (3) "no shows" within a 1 year time frame will result in dismissal from Allen Family Medicine.

Charges for Copies of Medical Records

You will be charged for copies of medical records as per the Medical Association, State and Federal guidelines. These charges cover the administrative cost of copying and mailing records.

- $15.00-per request of medical records (Labor cost)
- $0.50 per page for the first 25 pages
- $0.25 for page 26 and each additional page there after

Cash Pay/Fee for Service

- New patient visits range from $110.00 to $225.00 depending on complexity of the visit
- Established patient visits range from $40.00 to $110.00 depending on complexity of the visit

We require an upfront payment prior to your appointment with the Provider.

New patients -$120.00

Established patients- $84.00

Upon completion of your visit, the front desk will be able to either issue you a refund if the services rendered are less than the amount collected at the time of check in or request payment if the services rendered exceed the amount collected at the time of check in.

Checks

- We gladly accept checks as a form of payment. However, we DO NOT accept starter checks or checks from new patients.
- We charge a $50.00 returned check fee. If a check is returned on your account, you will no longer be able to write checks.
- If a check is returned on your account, payment will then need to be made by cash, debit card, money order, Visa or MasterCard.

Copay and Coinsurance

- We are required by your insurance plan to collect the copay at the time of your visit, even if you are sick.
- The copay amount is determined by your individual insurance policy.
- All payments are due at the time of service.

Deductibles

- Some insurance plans have deductibles.
- Our office policy is to collect $80.00 towards all deductible amounts.
- All deductible payments are due at the time of service.

Filing Secondary Insurances

Allen Family Medicine, as a courtesy, will file secondary insurance claims. However, it is the patient's responsibility to inform the office of secondary insurance coverage.

FMLA and other Disability Paperwork

There is a charge of $75.00 per form, payable prior to forms being completed. Please complete your portion, if any and provide pertinent information i.e.; dates of disability and return to work date. Please allow 5 business days to complete the form.

Insurance

- We are contracted with multiple insurers to accept assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the authorized copay, coinsurance and deductible at the time of services.
- If you have insurance coverage under a plan we are not contracted with, you will be treated as a cash pay/self-pay patient and will be provided documentation to assist you in filing your claim.
- If we are unable to verify your benefits, we will ask you to pay for your visit as a cash pay/self-pay patient.

Laboratory, Radiology and other Diagnostic Service Bills

Please check with your insurance company to verify what your schedule of benefits allows for any laboratory, x-ray or other diagnostic studies (bone densitometry, mammogram, etc.) that may be ordered by the doctor during your visit. These services will be billed separately by the laboratory/diagnostic facility that preformed these tests and are not covered by the payments that you make at this office. ***Any insurance claims or problems associated with an off-site laboratory must be dealt with/through that facility or their billing agent.***

Medicare Patients

- Please make sure you have a full understanding of your Medicare benefits and what might be your responsibility if not covered by Medicare.
- Your Provider wants to diagnose a condition you may have or evaluate how well your treatment is working. To do that the Provider needs to have certain diagnostic tests performed. The Provider will tell you what those tests are and why they are necessary, before your tests are performed. You may be asked to sign an Advanced Beneficiary Notice or "ABN". We ask patients to sign an ABN if Medicare appears likely to deny payment for a specific service. Medicare requires that we provide patients with a written notification whenever it is likely that you will be responsible for a bill.

Medicaid Patients

Please make sure your primary care physician or PCP has been changed to Dr. Gregory S. Allen prior to being seen.

Motor Vehicle Accidents

- We do not bill 3rd party motor vehicle insurance companies
- We do collect $216.00 at the time of service for services rendered

Outstanding Balances/Collections

- Prior to providing additional services to you, payment in full of total outstanding balances will be required.
- Outstanding balances will be referred to an outside collection agency. Once we receive an EOB (explanation of benefits) from your insurance, we will mail you a statement. If we do not receive payment within a reasonable time, your account will be referred to a collection agency and a 45% fee will be added to your account.

Patient Responsibility

- The patient or his/her legal representative is ultimately responsible for all charges for services rendered.
- "Non-Covered" means that a service will not be paid under your insurance contract. If non-covered services are provided, you will be expected to pay for these services at the time they are provided, or at the time receiving a statement or EOB from your insurance provider denying payment.
- Your insurance company offers appeal procedures. We will not under any circumstances falsify or change a diagnosis or symptom in order to convince an insurer to "pay" for care that is not covered, nor do we delete or change the content in the record that may prevent services from being considered covered. We cannot offer services without expectation of payment, and if you receive non-covered services, you must agree to pay for these services in the event that your insurance company does not.

Phone Appointments

Phone appointments are a rarity. If you need to discuss a health issue or abnormal test results, you will be asked to schedule an appointment to see your provider. Results usually take 7-10 days to reach our office or even longer depending on the testing you had performed.

Refunds

- Refunds are issued to the appropriate party within 2 weeks of a refund request. Patients refunds will not be processed until all active or past due charges are paid in full. Well visit and Problem/Sick visit on the same day.
- Some insurance companies will cover well visits and some will not. It is your responsibility to know what healthcare benefits your insurance covers prior to you visit. If you need to discuss any health problems that require evaluation and management, this must be documented and appropriately billed for you. *Your insurance company may not pau for additional problems that are addressed during the well exam. During your discussion with your provider, they will manage your problem first and may ask you to make another visit for your well exam.*

Workers Compensation Insurance

Allen Family Medicine does NOT accept Workers Compensation Insurance

If you have any questions regarding any of the above policies, please ask to speak to one of our office administrators for further clarification.

Patient's Medicare Authorization

Patient's Name: _____

Patient's Medicare No: _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to:

Allen Family Medicine

7233 E Baseline Rd. Ste. 126

Mesa, AZ 85209

For any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents and information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance' is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms electronically submitted claims my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicate carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicate carrier.

_____ _____

Patient Signature Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have received, read and understand the *Notice of Privacy Practices* containing a more complete description of the used and disclosers of mu health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I, may contact this organization at any time at the address below to obtain a current copy of *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I acknowledge receipt and have read and understand the Notice of Health Information Practices regarding my provider's participation in The Network, the statewide Health Information Exchange (HIE), or I previously received this information and have declined another copy.

Patient Name: _____ Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment of the Notice of Privacy practices Acknowledgement, but was unable to do so as documented below:

Date	Initials	Reason

Allen Family Medicine-7233 E. Baseline Rd., Ste. 126, Mesa, AZ 85209
Phone: 480-699-2222 Fax: 480-699-3033

AUTHORIZATON TO RELEASE MEDICAL RECORDS

Name: _____ Social Security #: _____
Address: _____
Date of Birth: _____ Phone #: _____

From: Name and address of facility, hospital or doctor records are being released from:
Name: _____ Phone #: _____
Address: _____ Fax #: _____

To: Name and address of facility, hospital or doctor records are being released to:
Name: ALLEN FAMILY MEDICINE Phone #: (480) 699-2222

Address: 7233 BASELINE RD, STE. 126, MESA, AZ 85209 Fax #: (480) 699-3033

I authorize the release of copies of the medical records in the possession or control of the above named facility, its employees and/or agents. These medical records may include confidential records such as HIV related information (as defined A.R.S section 36-661) and/or confidential alcohol or drug abuse related information (as defined in 42 CFR section 2.1 et seq.) and/or confidential mental health diagnostic and /or treatment information.

Records to be released (check one and specify details if appropriate):

IF MORE THAN 25 PAGES PLEASE MAIL TO THE ABOVE ADDRESS

_____ All medical records (Progress notes. Labs and Imaging only)
_____ Medical records of the last ____ years of treatment only
_____ Medical records from the following period only _____ to _____

_____ Records pertaining to _____ (specify injury or illness)

I have read and completed the above or have had the information completed on my behalf freely, voluntarily and without coercion. This authorization is valid for six (6) months from the date of signature. I may revoke this authorization at any time provided I notify Allen Family Medicine in writing to the effect. I understand that any release which was made in compliance with this release prior to my revocation of the authorization shall not constitute a breach of my rights to confidentiality. I understand that a photocopy of this authorization is considered acceptable in lieu of the original.

Patient or guardian Name: _____

Patient or guardian Signature: _____ Date: _____

Health Insurance Portability and Accountability Act (HIPAA)
Patient Authorization to Disclose Form

Dear patient,

The Health Insurance Portability and Accountability Act (HIPAA) require us to provide you with notice of our privacy practices. The privacy notice includes our policies on reviewing, amending, and/or copying your protected health information (PHI).

Our goal is to protect your privacy, and we encourage you to read the notice of our privacy practices.

Please review the following before signing:

1. I understand that my individual protected health information (PHI) may be used and disclosed to carry out treatment, payment or healthcare oversight activities.
2. I understand that 1 may request that Allen Family medicine (AFM) restrict how my individual identifiable protected health information is used or disclosed to carry out treatment, payment or healthcare oversight activities. AFM is not required to agree to requested restrictions, but if AFM agrees to a requested restriction, the restriction will be binding.
3. I understand that I may revoke the consent at any time by notifying AFM in writing, except to the extent AFM has taken action in reliance on the consent.
4. 1 may restrict the use and disclosure of my PHI related to psychiatric care, drug and alcohol abuse and HIV/Aids, except for the purpose of treatment, payment or healthcare operations.
5. I have been provided or offered a copy of AFM's HIPAA statement and privacy notice.

I give permission for AFM to disclose to the below mentioned individuals any and all of my protected health information:

Name	Relationship	Contact number
_____	_____	_____
_____	_____	_____

Patient Name: _____ DOB: _____

Signature: _____

Parent/Guardian Signature: _____
(If under the age of 18yr.)

Revised: 01/02/2019

Allen Family Medicine-7233 E. Baseline Rd., Ste. 126, Mesa, AZ 85209
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MEDICAL HISTORY FORM

Patient Name: _____ DOB: _____ Age: _____
Today's date: _____

To help us meet all your healthcare needs, please fill out this form completely. Do not leave any fields blank. This is a confidential record of your medical history and will be kept in the office.

HEIGHT: _____FT _____IN WEIGHT: _____LBS

When was your last Physical Exam: _____ When was your last Dexa Scan _____

When was your last Pap smear _____ When was your last Mammogram _____

When was your last Colonoscopy _____ When was your last Prostate Exam _____

1. PAST MEDICAL HISTORY-Have you ever had any of the following? **Please CIRCLE**
   _____Patient denies any PMH

ANEMIA	HEPATITIS	SYNCOPE/COLLAPSE
ARTHIRITIS	HYPERTENSION	SEIZURES
ASTHMA	IRRITABLE BOWEL	SKIN CANCER
BLADDER PROBLEMS	KIDNEY PROBLEMS	STD
CANCER (Describe)	LEG/LUNG CLOTS	TIA
HIGH CHOLESTEROL	LIVER DISEASE	THYROID DISORDER
CVA	MIGRAINES	ULCERS
DEPRESSION/ANXIETY	OSTEOPOROSIS	UTERINE FIBROIDS
DIABETES TYPE 1	PMS/PCOS	OTHER ILLNESS _____
DIABETES TYPE 2	PNEUMONIA	OTHER ILLNESS _____
ENDOMETRIOSIS	ROSACEA	OTHER ILLNESS _____
GERD/ACID REFLUX	SENILE DEMENTIA	
HEART DISEASE	SINUSITIS	
HEART FAILURE	SLEEP DISORDERS	

2. PAST SURGICAL HISTORY-Have you ever had any of the following, please list all serious illness, operation and other hospitalizations you have experienced and **indicate the year it occurred**.
   _____Patient denies any PMH

APPENDIX _____

BACK SURGERY _____

BREAST BIOPSY (left or right) _____

BREAST SURGERY (left or right) _____

CATARACT SURGERY (left or right) _____

COSMETIC_____

C-SECTION _____

D & C_____

GALLBLADDER _____

HERNIA REPAIR_____

HYSTERECTOMY (full or partial) _____

TUBAL LIGATION _____

TONSILS/ADENOIDS _____

OTHER _____

OTHER _____

OTHER _____

OTHER _____

OTHER _____

3. MEDICATIONS: Please list ALL MEDICATIONS you are currently taking (including OTC)
   _____Patient denies taking any medications

MEDICATION	DOSAGE	HOW OFTEN PER DAY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. PLEASE LIST ANY ALLERGIES (including medication, food and environmental)
   _____Patient denies any allergies

_____
_____
_____

5. FAMILY HISTORY-Has any blood relative had any of the following, **if so please list RELATIONSHIP**; Leave blank if uncertain.

BREAST CANCER _____
DEPRESSION_____
DIABETES_____
ELEVATED CHOLESTROL_____
GENETIC PROBLEMS_____
HEART DISEASE_____
HYPERTENSION_____
KIDNEY PROBLEMS_____

DVT/BLOOD CLOTS_____
OSTEOPOROSIS_____
SEIZURE DISORDER_____
BLEEDING DISORDER_____
THYROID DISORDER_____
OTHER_____
OTHER_____
OTHER_____

6. MENSTRUAL HISTORY

Last Menstrual Cycle: _____
Age Menopause:_____

Method of Birth Control: _____
Menopause Status: _____

Hormone Replacement Therapy? YES or NO

7. IMMUNIZATIONS-Please list all immunization that you have had in the last 5 years, including flu vaccines

_____ _____
_____ _____
_____ _____
_____ _____

8. SOCIAL HISTORY

Tobacco:	□Never	□Minimal	□Yes (____packs/day)	□Quit _____yrs. ago	
Alcohol:	□Never	□Less than 10/wk		□More than 10/wk	
Illicit Drugs:	□Never	□Minimal	□Yes		
Marital Status:	□Single	□Married	□Widowed	□Divorced	□Separated
Education Level:	□High School	□College	□Post Graduate	□Other	

9. REVIEW OF SYSTEMS: Do you have nor or have you had any of the below problems within the LAS T YEAR (Please circle all that apply:

Constitutional:	Fatigue	Weight Change	Fever/Chills		
Eyes:	Glaucoma	Blurred vision			
Hent:	Headache	Hearing changes	Sinus problems	Sore throat	
	Ringing in the ears				
Breast:	Tenderness	Nipple discharge			
Cardiovascular:	Chest pain	Irregular heartbeat	Syncope	Swelling	
Respiratory:	Wheezing	Shortness of breath	Frequent cough		
Gastrointestinal:	Abd pain	Diarrhea	Constipation	Nausea	Vomiting
Genitourinary:	Nocturia	Change in stream	Painful urination	Frequent urination	
Integument:	Rash	Moles	Skin tags		
Neurological:	Tremors	Numbness/tingling	Dizzy spells		
Endocrine:	Excess. Thirst	Hot/cold	Tired/sluggish	Hot flashes	
Psychiatric:	Anxiety	Depression	Suicidal ideation	Homicidal ideation	
Hemme-lymph:	Bruising	Swollen glands	Blood clotting problems		
Allergic-immun:	Hay fever	Drug allergies	Food allergies	Excess infections	

How did you hear about us?

_____

_____

_____

Please feel free to share any comments about our office.

_____

_____

_____

_____ _____

Signature of patient of parent of minor Date

Allen Family Medicine-7233 E. Baseline Rd., Ste. 126, Mesa, AZ 85209
Phone: 480-699-2222 Fax: 480-699-3033

Chart Update

Provider: _____ Specialty Tech: _____ Date: _____

Check if answering Yes:

1. I suffer from allergies □Airborne □Food
2. My allergies flare up in the □Spring □Fall
3. I often suffer from a stuffy or runny nose □
4. I often suffer from watery, itchy eyes □
   And/or _____
5. I often suffer from an itchy throat or coughing when I'm not sick □
6. I feel or have been told that I have ongoing sinus infections □
7. I often suffer from wheezing or other asthma like symptoms □
8. I often suffer from rashes and/or hives □
9. I have other skin problems (describe in note area) □
10. I have tried using the following medications:
    □ Over the counter sinus and/or allergy medication. _____Months/Years
    □ Prescription sinus and/or allergy medications including: Inhalers. Steroids, Pills
    (List names, types and for how long in the notes area)
11. If I could become desensitized to allergies so that they no longer affect me,
    I would be very interested in learning about your allergy program □

Notes/Comments:

_____

_____

_____

Please check if any of the following are true:

I am or may be pregnant □
I currently take heart medication □
I currently take blood pressure medication □
I have taken sleep aids, antidepressants, antihistamines within the past 7 days □
I have been tested for allergies in the past □
I have had anaphylactic reaction in the past □
I have an allergy to latex □

Patient Signature: _____Date: _____

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