

**Patient Intake Form**  
Maahir Haque MD



Patient Name \_\_\_\_\_

Age \_\_\_\_\_ DOB \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Date \_\_\_\_\_ How did you hear about Dr. Haque? \_\_\_\_\_

**Chief Complaint:** what is the main reason for your visit? If you have more than one, **please clarify what percentage of your problem falls under each category.**

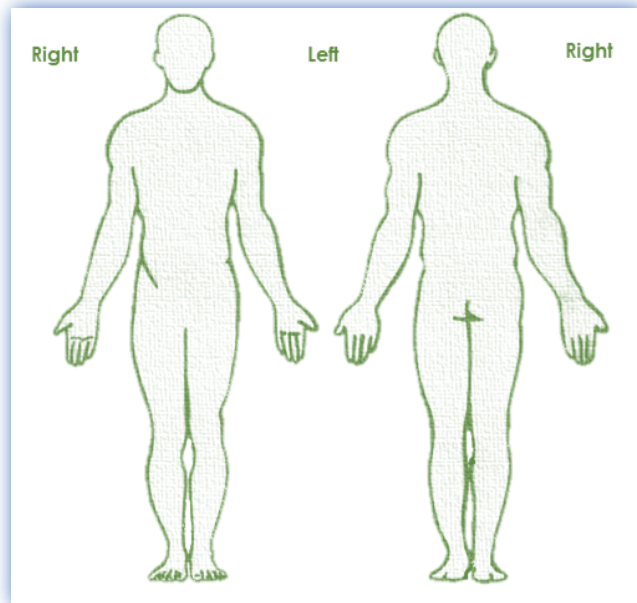
Back Pain \_\_\_\_\_%     Leg Pain \_\_\_\_\_%     Neck Pain \_\_\_\_\_%     Arm Pain \_\_\_\_\_%

How **severe** is your pain? 0=no pain 10=worst pain imaginable

Today's Pain	0	1	2	3	4	5	6	7	8	9	10
Worst Pain	0	1	2	3	4	5	6	7	8	9	10
Best Pain	0	1	2	3	4	5	6	7	8	9	10

**Pain Drawing:** Please indicate **where** your pain is and **what type** of pain you have using the key to the left.

Key	
////	Stabbing
XXX	Burning
0000	Pins & Needles
===	Numbness
+++	Aching



**Describe** your symptoms (severity, location, timing, frequency):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

What **increases** your pain?

- Sitting/Driving       Leaning Forward       Standing       Walking       Lying down

What **relieves** your pain?

- Sitting/Driving       Leaning Forward       Standing       Walking       Lying down

What caused your back issue? Was there **trauma**?

- Yes       No       Car accident       Work accident/injury

If so, **describe when/where/how** you were hurt: \_\_\_\_\_

**How long** have you had symptoms for?

- <6 weeks       <3 months       3 months – 1 year       >1 year

**Progression:** Are your symptoms **worsening/staying the same/improving**? \_\_\_\_\_

What is your **occupation**? \_\_\_\_\_

Are you still **working**?

- Yes/Full duty       Light duty       I am on temporary disability       I am fully disabled because of \_\_\_\_\_       Retired

Have you experienced any of the following recently?

- Arm or Leg **Weakness**       **Numbness**       **Loss of bowel control**       **Loss of bladder control**  
 Unsteadiness on your feet       Hand clumsiness, trouble with handwriting or buttoning a shirt       Recent illness       Recent **fevers**  
 Night Pain       Unintentional Weight Loss       Chest Pain       Shortness of Breath

Have you seen another physician about your back/neck problems? Who and when?

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

What if any **treatment** have you received?

<input type="checkbox"/> Surgery	<input type="checkbox"/> Injections	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Chiropractor	<input type="checkbox"/> Other:
Date(s)	Date(s)	Year		
_____	_____	_____		_____
_____	_____			_____
_____	_____			_____
_____	_____			_____
Procedure(s)	Type(s)	Number of Weeks/Visits		
_____	_____	_____		_____
_____	_____			_____
_____	_____			_____
_____	_____			_____

What **testing** has been done on your spine?

MRI     
  CT     
  X-ray     
  EMG     
  Other: \_\_\_\_\_

Are you **allergic to latex**? What reaction did you have and when? \_\_\_\_\_

Have you had any bad reactions to anesthesia? \_\_\_\_\_

Do you take a **blood thinner**? Which and why do you take it? \_\_\_\_\_

Have you ever had a **DVT, PE, or blood clot**? When? Is there a family history? \_\_\_\_\_

Do you have trouble with **easy bruising or excessive bleeding**? \_\_\_\_\_

Female patients: Are you or could you be **pregnant**? \_\_\_\_\_

**Social History**

Do you **smoke** or use tobacco? How much, for how long? \_\_\_\_\_ packs/day for \_\_\_ years

Have you quit smoking? When, for how long? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ drinks every \_\_\_\_\_

Have you used illegal drugs? Which? Have you used prescription medicines other than as prescribed? \_\_\_\_\_

Do you **exercise**? How often? What do you do? \_\_\_\_\_

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**Review of Systems** – do you have any issues with the following body systems?

General

- Weight loss or gain
- Fatigue
- Fevers or Chills
- Weakness
- Trouble sleeping

Eyes

- Vision loss/changes
- Glasses or contact use
- Pain
- Blurry vision
- Flashing lights
- Specks
- Glaucoma

Ears/nose/mouth/throat

- Ears:* Decreased hearing
- Ringing in ears
- Drainage
- Nose:* Stuffiness
- Discharge
- Nosebleeds
- Mouth/throat:* Bleeding
- Dentures
- Soreness
- Hoarseness
- Thrush

Respiratory

- Cough
- Sputum
- Coughing up blood
- Shortness of Breath
- Wheezing

Allergy/immunizations

- Hay fever
- Itching

Cardiology/vascular

- Chest pain, tightness, or discomfort
- Palpitations
- Shortness of breath with activities

Difficulty breathing lying down

- Extremity swelling
- Awakening with shortness of breath

Psychiatric

- Nervousness
- Stress/anxiety
- Depression
- Memory loss

Gastrointestinal

- Swallowing difficulty
- Change in appetite
- Nausea
- Change in bowel habits
- Rectal bleeding
- Constipation
- Incontinence of stool

Genitourinary

- Infertility
- Burning or pain
- Blood in urine
- Incontinence

Musculoskeletal

- Muscle or joint pain
- Stiffness
- Back pain
- Redness of joints
- Swelling of joints
- Trauma

Neurological

- Dizziness
- Fainting
- Seizures
- Weakness
- Numbness
- Tingling
- Tremor

Endocrine

- Sweating
- Frequent urination
- Thirst

Hematological/lymphatic

- Swollen glands
- Easy bruising
- Easy bleeding

Skin/Integumentary

- Rashes
- Lumps
- Itching
- Dryness
- Color changes
- Hair and nail changes

Please **Sign** below:

\_\_\_\_\_

**Date:** \_\_\_\_\_



2954 Mallory Circle, Suite 101 • Celebration, FL 34747  
 2400 N Orange Blossom Trail, Suite 100 • Kissimmee, FL 34744  
 4741 Old Canoe Creek Road • St. Cloud, FL 34769  
 7350 Sand Lake Commons Blvd, Suite 1102 • Orlando, FL 32819  
**Phone:** (321) 939-0222 • **Fax:** (321) 939-0225

**BRAD HOMAN, DO**  
*Joint Replacement & Sports Medicine*

**MATTHEW JOHNSTON, DO**  
*Joint Replacement & Sports Medicine*

**JOSEPH E. ROBISON, MD**  
*Hand & Wrist Surgery*

**MAAHIR HAQUE, MD**  
*Spine Surgery*

**JOSE AMUNDARAY, MD**  
*Joint Replacement Specialist*

**JOSHUA BRITT, DPM**  
*Foot & Ankle Surgery*

**J. DOUGLAS McDONALD, MD**  
*Sports Medicine*

**DAVID LALLI, DO**  
*Joint Replacement & Sports Medicine*

**AYMAN DAOUK, MD**  
*Joint Replacement & Sports Medicine*

**MATTHEW WILLEY, MD**  
*Physical Medicine & Rehabilitation*

## PATIENT INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
*Apellido Nombre inicial del segundo nombre*

Birth day \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
*Cumpleaños teléfono Seguro social*

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
*Dirección ciudad estado código postal*

Email \_\_\_\_\_ Sex:  M  F  
*Correo electrónico género*

Whom may we thank for referring you? \_\_\_\_\_  
*Quien lo refirió*

Referring Physician (If Applicable) \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
*Médico de referencia (si corresponde) teléfono*

Marital Status:  Single  Married  Divorced  Widowed  Separated  Partnered  
*estado civil solo casado divorciado viudo apartado asociado*

Who is Responsible for Patient?  Self  Parent  Employer  Other \_\_\_\_\_  
*¿Quién es Responsable de Paciente? Yo padre empleador otro*

Person to contact in case of emergency \_\_\_\_\_ Relationship \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
*Persona de contacto en caso de emergencia relación teléfono*

**\*\*\*Who may we share Medical Information with?**  
*¿Con quién podemos compartir información médica?*

Name \_\_\_\_\_ Relationship \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
*Nombre relación teléfono*

Name \_\_\_\_\_ Relationship \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
*Nombre relación teléfono*

## INSURANCE INFORMATION

Primary Insurance Co. \_\_\_\_\_  
*seguro primario*

Name of Insured \_\_\_\_\_  
*Nombre del Asegurado*

Relationship to Patient \_\_\_\_\_  
*Relación con el Paciente*

Secondary Insurance \_\_\_\_\_  
*seguro secundario*

Name of Insured \_\_\_\_\_  
*Nombre del Asegurado*

Relationship to Patient \_\_\_\_\_  
*Relación con el Paciente*

## ACCIDENT INFORMATION

Was the Accident:  Work-Related  Auto-Related  Other \_\_\_\_\_  
*¿cuál fue el accidente? relacionados con trabajo auto relacionados otro*

Employer \_\_\_\_\_ Date of Injury \_\_\_\_\_  
*Empleador fecha de la lesión*

Time of Injury \_\_\_\_\_ Place of Injury \_\_\_\_\_  
*momento de la lesión lugar de la lesión*

Do you have notice of Injury on file?  Yes  No W.C. Claim # \_\_\_\_\_  
*¿Tiene la notificación de lesiones? Si No numero de reclamo*

Attorney Name \_\_\_\_\_ Insurance Co. \_\_\_\_\_  
*nombre del abogado compañía de seguros*

Policy Holder \_\_\_\_\_ I.D. # \_\_\_\_\_  
*Tomador I.D. número*

Address \_\_\_\_\_ Zip \_\_\_\_\_  
*Dirección código postal*

Phone (\_\_\_\_\_) \_\_\_\_\_ were X-Rays taken of this Injury? Yes  No   
*Teléfono fueron radiografías tomadas de esta lesión? Si No*

If yes, where were X-Rays taken? \_\_\_\_\_ Date \_\_\_\_\_  
*En caso afirmativo, ¿dónde estaban radiografías tomadas? fecha*

**PLEASE HAVE YOUR INSURANCE CARD AND DRIVER'S LICENSE READY FOR RECEPTIONIST. PAYMENT FOR PROFESSIONAL SERVICE IS DUE AND PAYABLE WHEN SERVICE IS RENDERED.**

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Sign: \_\_\_\_\_ Date: \_\_\_\_\_  
*Firma fecha*

Relationship (if not signed by patient) \_\_\_\_\_  
*Relación (si no es firmado por el paciente)*

I wish to provide the following restrictions on disclosure of my health information:  
*Deseo dar las siguientes restricciones a la divulgación de mi información de salud:*

\_\_\_\_\_

**Internal Use ONLY:** If patient/patient's representative declines to sign acknowledgement, please document date and time notice as presented to patient and sign below.

Date/Time \_\_\_\_\_ Name/Title \_\_\_\_\_

## RELEASE OF MEDICAL RECORDS

I hereby authorize the release of medical, psychiatric, alcohol and HIV testing and/or drug abuse information for insurance carriers or for continuing patient care. I further agree to have my physician maintain my health information data for the purpose of education, research and publication in professional journals and medical books. However, any publication of these will exclude my name so as to protect my identity.

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_

Signature of Parent/Guardian and/or Responsible Party \_\_\_\_\_ Date \_\_\_\_\_

# CONSENT FOR EVALUATION OR TREATMENT

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Undersigned hereby consents to whatever evaluation or treatment the assigned physician deems necessary to the above named patient.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian and/or Responsible Party

\_\_\_\_\_  
Date

# INSURANCE ASSIGNMENT AND RELEASE

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I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to **Celebration Orthopaedic & Sports Medicine Institute** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named physician may use my healthcare information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian and/or Responsible Party

\_\_\_\_\_  
Date

# MEDICARE/MEDIGAP AUTHORIZATION

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Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Medicare #: \_\_\_\_\_ Patient ID #: \_\_\_\_\_

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to **Celebration Orthopaedic & Sports Medicine Institute**, for any services furnished to be by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare or Medicaid Services, any Medigap insurer, and their agents any information needed to determine these benefits and related services.

\_\_\_\_\_  
Signature of Patient, Patient Guardian, or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name of Parent/Guardian and/or Representative

\_\_\_\_\_  
Relationship to Patient

# FINANCIAL AGREEMENT

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Thank you for choosing Celebration Orthopaedic & Sports Medicine Institute as your healthcare provider. We are committed to your treatment being successful and we appreciate your trust in us. The following is a statement of our Financial Policy which you are required to read and sign. Our staff will address any questions that you may have but you will need to agree to and sign prior to your treatment being rendered:

- **Self pay patients** - Payment in full is due at the time of service.
- **Patients with Insurance** - We will file your insurance claim for you. However, in order to work with your insurance company, we must have complete and current information, a copy of your insurance card and your signature on file.
- **Insurance benefits** – It is your responsibility to know your insurance benefits. Please contact your insurance company with any questions that you may have regarding coverage of orthopaedic services.
- **Co-payments, co-insurances and deductibles** – All patient balances are due at time of service. We accept cash, checks as well as Visa, MasterCard, Discover and American Express credit cards.
- **Non Covered Charges** - Please understand there may be some charges for our services which your insurance company considers non-covered and may be excluded from your policy. Accordingly, you will be responsible for these charges.
- **Denied Claims** - You will be responsible for any charges that are denied by your insurance company which result from your failure to provide our office with complete and current information in a timely manner.
- **Medicare** - We are a participating Medicare provider. We will bill Medicare, as well as any secondary insurance that you may have, for you. However, that does not mean that all services are covered. Additionally, you are responsible for any copayments, usually 20% of the allowed amount, as well as any unmet annual deductible. Please realize that Medicare may allow a service but your secondary may not so you will be responsible for that portion.
- **Missed appointments** - Failure to cancel an appointment within 24 hours will be subject to a \$10 patient charge. (\$50 will be charged for MRI's and Laser's) This is an internal charge and cannot be billed to your insurance company.
- **Returned checks** – Any returned check is subject to a \$25 bank fee.
- **Special financial arrangements** – We offer monthly payments plans with balances to be paid off in 4 consecutive payments. Also, we offer financial hardship discounts but these required the patient to complete a Financial Evaluation Form with proper supporting documentation that shows the patient's income.
- **Past due accounts** – All past due accounts are subject to collection proceedings. All fees including but not limited to the maximum interest that is allowable by law, a 35% collection agency fee and awarded court fees will become your responsibility in addition to the patient balance should you be placed with an external collection agency.

## I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE FINANCIAL POLICY

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Signature of Patient, Patient Guardian, or Personal Representative

---

Date

---

Print name of Parent/Guardian and/or Representative

---

Relationship to Patient





## Clinical History - Please Complete

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Last Physical Date: \_\_\_\_\_

Please Note, items left blank indicate a negative response

### PAST MEDICAL HISTORY None Indicate **all** medical conditions you have experienced.

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Liver disorder    | <input type="checkbox"/> Osteoporosis         |
| <input type="checkbox"/> Blood clots/DVT    | <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Stomach ulcers    | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Stroke             | <input type="checkbox"/> Arrhythmia          | <input type="checkbox"/> Kidney problems   | <input type="checkbox"/> Gout                 |
| <input type="checkbox"/> Seizures           | <input type="checkbox"/> Anemia              | <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Fibromyalgia         |
| <input type="checkbox"/> Sleep apnea        | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Cancer            | <input type="checkbox"/> Psoriasis            |
| <input type="checkbox"/> Asthma/Emphysema   | <input type="checkbox"/> Thyroid disorders   | <input type="checkbox"/> Glaucoma          | <input type="checkbox"/> Other (list below)   |

### SURGICAL PROCEDURES None Indicate **all** surgical procedures (include approximate date)

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Tonsils _____  | <input type="checkbox"/> Heart _____        | <input type="checkbox"/> Uterus _____   | <input type="checkbox"/> Prostate _____              |
| <input type="checkbox"/> Appendix _____ | <input type="checkbox"/> Colon _____        | <input type="checkbox"/> Breast _____   | <input type="checkbox"/> Hernia _____                |
| <input type="checkbox"/> Thyroid _____  | <input type="checkbox"/> Gall Bladder _____ | <input type="checkbox"/> Vascular _____ | <input type="checkbox"/> Other (list in space below) |

### FAMILY HISTORY None Indicate **all** medical conditions experienced by any parent, sibling, or child

- |                                   |  |   |   |
|-----------------------------------|--|---|---|
| <input type="checkbox"/> Cancer   | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Problems    | <input type="checkbox"/> Osteoporosis             |
| <input type="checkbox"/> Stroke   | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Birth defects            |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Blood clots/DVT    | <input type="checkbox"/> Anesthesia complications |

# SOCIAL HISTORY

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Occupation: \_\_\_\_\_  Student  Retired  Disabled

Marital Status:  Single  Married  Divorced  Widowed  Partnered

Do you smoke or use tobacco?  Yes  No If Yes, How Much? \_\_\_\_\_

Do you drink alcohol?  Yes  No If Yes, How Much? \_\_\_\_\_

Do you exercise regularly?  Yes  No If Yes, how often? \_\_\_\_\_

**REVIEW OF SYSTEMS**  None Indicate **all** symptoms you are currently experiencing

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- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Fevers/Night sweats | <input type="checkbox"/> Shaking/Chills            | <input type="checkbox"/> Recent weight loss        | <input type="checkbox"/> Bleeding gums          |
| <input type="checkbox"/> Frequent headaches  | <input type="checkbox"/> Depression                | <input type="checkbox"/> Shortness of breath       | <input type="checkbox"/> Coughing up blood      |
| <input type="checkbox"/> Nausea/Vomiting     | <input type="checkbox"/> Heartburn                 | <input type="checkbox"/> Blood in stools           | <input type="checkbox"/> Loose stools           |
| <input type="checkbox"/> Rashes              | <input type="checkbox"/> Anxiety                   | <input type="checkbox"/> Bruising/Bleeding easily  | <input type="checkbox"/> Calf cramps            |
| <input type="checkbox"/> Frequent nosebleeds | <input type="checkbox"/> Visual problems           | <input type="checkbox"/> Hearing problems          | <input type="checkbox"/> Dizziness/Fainting     |
| <input type="checkbox"/> Hoarseness          | <input type="checkbox"/> Chest pain                | <input type="checkbox"/> Abnormal heartbeat        | <input type="checkbox"/> Ankle or foot swelling |
| <input type="checkbox"/> Loss of appetite    | <input type="checkbox"/> Difficulty with urination | <input type="checkbox"/> Pain/Burning on urination | <input type="checkbox"/> Blood in urine         |
| <input type="checkbox"/> Joint pain          | <input type="checkbox"/> Joint swelling            | <input type="checkbox"/> Loss of height            | <input type="checkbox"/> Irregular periods      |

**MEDICATIONS**  None List **all prescription** and **non-prescription** medications and supplements.

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Name of Medication	Strength/Dose	Frequency
_____		
_____		
_____		
_____		
_____		

**ALLERGIES**  None Indicate **all** allergies you have to **medications** and **foods**.

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Allergy	Reaction
_____	
_____	
_____	
_____	

**CONFIDENTIAL INFORMATION**  None Indicate **all** conditions for which you have received treatment

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- Mental health conditions (depression, anxiety, etc.)  HIV / AIDS  
 Substance abuse (alcohol, narcotics, etc.)  Sexually transmitted diseases (STD's)  
 Illegal drug use  Minor pregnancies (pregnancy under the age of 18)

If you have indicated any of the conditions above, **please initial** the corresponding categories listed below which will authorize **Celebration Orthopaedic & Sports Medicine Institute** to disclose that information to third parties for treatment or payment purposes in the event that it is requested by said third parties or required by law.

Initials: \_\_\_\_\_ Mental health information      Initials: \_\_\_\_\_ HIV/AIDS information

Initials: \_\_\_\_\_ Substance abuse information      Initials: \_\_\_\_\_ STD information

Initials: \_\_\_\_\_ Illegal drug use information      Initials: \_\_\_\_\_ Minor pregnancy information

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Are you pregnant or could you be pregnant?  No  Yes      If yes, due date: \_\_\_\_\_

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**\*\*I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT. I AM THE PATIENT OR AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE TERMS.**

\_\_\_\_\_  
Signature of Patient, Patient Guardian, or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name of Parent/Guardian and/or Representative

\_\_\_\_\_  
Relationship to Patient



## Consent for Electronic Prescribing

Patient Name: \_\_\_\_\_

Patient Portal Number: \_\_\_\_\_

Celebration Orthopaedic & Sports Medicine Institute is enrolled in an electronic prescribing program. This program is meant to help our providers with understanding what medications our patients are currently using and to give them the best possible treatment.

By signing this form, you are consenting to allow Celebration Orthopaedic & Sports Medicine Institute to retrieve electronic prescribing information from other providers through the Sure Scripts database.

\*\*I agree that Celebration Orthopaedic & Sports Medicine Institute may request and use my prescribing medication history from other healthcare providers.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date of Consent

Pharmacy Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

## OFFICE POLICY FOR PRESCRIPTION REFILL REQUESTS

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We require a 48 hour notice for all prescription refill requests.

Please leave the following information on the Medical Assistant's voice mail when calling:

- **Your Name & Telephone Number**
- **Your Physician's Name**
- **Pharmacy Telephone Number**
- **Medication Name & Strength**

Please Initial: \_\_\_\_\_

Today's Date: \_\_\_\_\_