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**ENG/VENG Patient Instructions**

**Patient’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Appointment Date & Time:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

An Electronystagmography (ENG) or Video Electronystagmography (VENG) has been ordered by your physician to help determine the cause of your dizziness or balance problems. The procedure is painless and will last 60-90 minutes. During the test, eye movements will be recorded while you follow lights and lay in different positions, and while warm and cool air are introduced into each ear canal. Recordings will be made with infrared goggles.

Please arrive 15 minutes prior to testing time to complete patient registration.

So that we can obtain the most accurate results, please review the following instructions:

* Medications greatly influence the test results. For 48 hours (two days) prior to your test do NOT take any of the following medications as they will affect the test results. If you are unsure about discontinuing any medication, contact your prescribing physician.
  + Anti-nausea or anti-dizziness medications (Antivert, Meclizine, Dramamine, etc.)
  + Antihistamines, Decongestants, or Cold Pills (Dimetapp, Benadryl, Claritin, Allegra, etc.)
  + Sedatives and Sleeping Pills (Halcion, Restoril, Xanax, Ambien, etc.)
  + Tranquilizers (Valium, Librium, Atarax, Serax, etc.)
  + Pain relievers or Narcotics (Aspirin, Codeine, Demerol, Percocet, etc.)
  + Stimulants, Amphetamines, or Appetite Suppressants (Adderall, Vyvanse, Adipex, etc.)
  + Alcohol (Beer, Wine, Liquor, Cough Medicine, etc.)
* Vital medications SHOULD NOT be stopped. Continue to take medications for heart, blood pressure, thyroid, birth control, antidepressants, anti-seizure and diabetes.
* Wear comfortable clothing (preferable slacks) that allows you to move easily.
* Do not wear any makeup, especially mascara and eyeliner.
* If you wear glasses, please bring them. If you wear contacts, please bring both glasses and contacts. You may need to remove contacts for testing.
* Do not drink caffeinated beverages such as coffee, tea or cola 48 hours prior to the test.
* Do not eat or drink 4 hours prior to your test. If you are diabetic or prone to lightheadedness, you may have a small, light meal or glass of juice. You will not be put to sleep, but you will be more comfortable during the test with an empty stomach.
* Bring a driver. Your driver should remain in the building during testing. Testing may leave you with a short-lived feeling of imbalance and it is helpful to have someone drive you to and from the test.

Please feel free to call 337-291-9939 with any questions.

**110 Exchange Place**

**Suite 100**

**Lafayette, LA 70503**

**P: 337-291-9939**

**F: 337-291-9023**

# 

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**Last:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **First:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **M.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Zip Code:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary#** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Work#** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell#** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **SSN:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Gender:**Male Female

**E-Mail:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Marital Status:** Married Single Widowed Divorced

**Appointment reminders?** Email Text Call **Primary Physician:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employment/Student Status:** Full Part Time Retired Not Employed

**Responsible Party Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **D.O.B.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone#** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State:** \_\_\_\_\_\_\_ **Zip:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How did you hear about our services?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance**

**Primary:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Policy #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Grp. #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insured’s name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to Insured:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Employer:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Notice of Privacy Practices Written Acknowledgement Form**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ has received a copy of **Selective Hearing’s Notice of Privacy Practices.**

**(Patient Name)**

**Signature of patient or guardian:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby assign, transfer, and set over to Selective Hearing all my right, titles, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until I give written notice revoking the said authorization.

**I understand that I am financially responsible for all charges whether they are covered by insurance.** This authorization is also valid for release of medical records concerning my illness and treatment.

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

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**110 Exchange Place**

**Suite 100**

**Lafayette, LA 70503**

**P: 337-291-9939**

**F: 337-291-9023**

**Balance History Questionnaire**

**Patient’s Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please answer all questions to the best of your ability.

I. When you are “dizzy” do you experience any of the following symptoms? (circle yes or no)

1. Light-headedness or swimming sensation in the head? Yes No

2. Blacking out or loss of consciousness? Yes No

3. Tendency to fall? to the: left right forward backward

4. Objects spinning or turning around you? Yes No

5. Sensation that you are spinning or turning? Yes No

6. Loss of balance while walking? veering to the: left right

7. Headache? Yes No

8. Nausea or vomiting? Yes No

9. Pressure in the head? Yes No

10. Tingling in your fingers, toes or around your mouth? Yes No

II. Please circle yes or no and fill in the blanks answering all questions

1. My dizziness is: Constant In attacks or episodes

2. When did the dizziness first occur?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

3. If in attacks: How often do attacks occur?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long do they last?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was the first episode?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was the duration of the shortest attack?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any warning that it is going to occur? Yes No

Do they occur at any particular time of day or night? Yes No

Are you completely free of dizziness between attacks? Yes No

4. Does change of position make you dizzy? Yes No

5. Do you have trouble walking in the dark? Yes No

6. When you are dizzy, must you support yourself when standing? Yes No

7. Do you know any possible cause of your dizziness? Yes No

8. Do you know of anything that will:

Stop your dizziness or make it better? Yes No

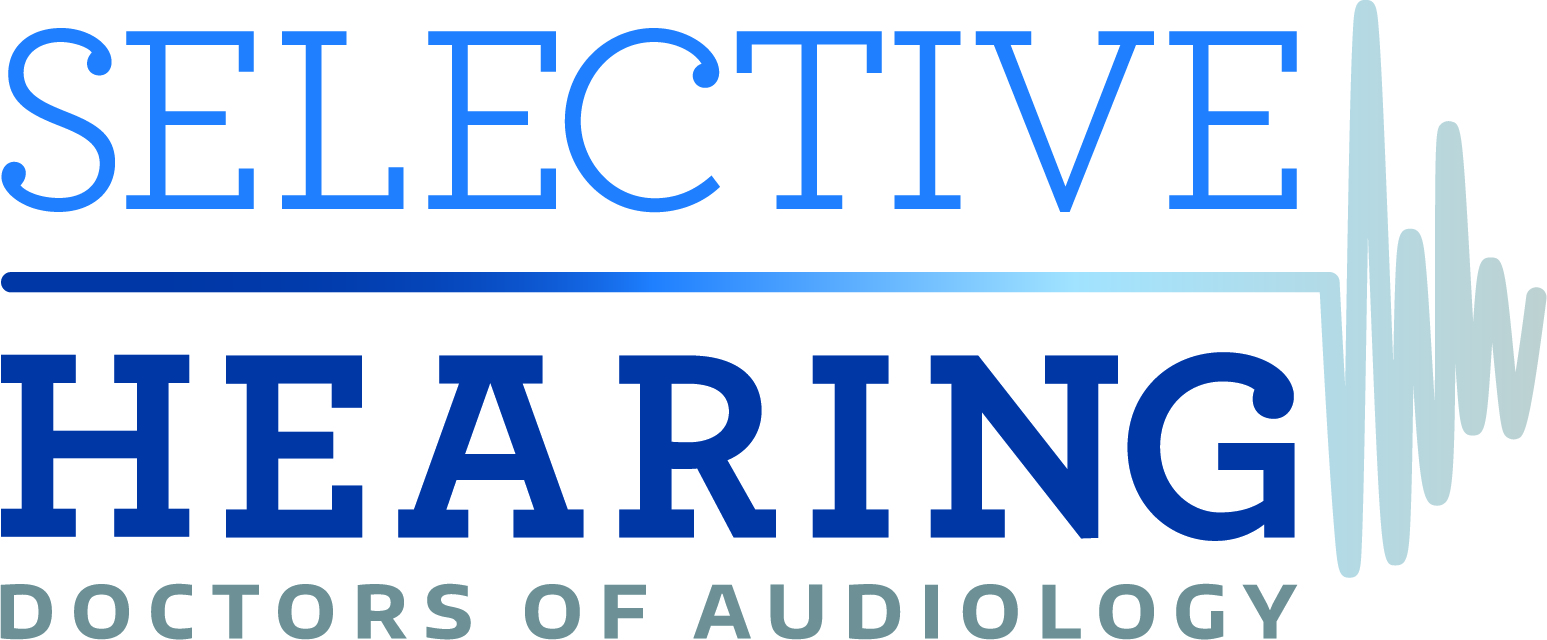
Make your dizziness worse? Yes No

Precipitate an attack? Yes No

(e.g.: fatigue, exertion, hunger, menstrual period, stress, emotional upset, alcohol)

If you answered “yes” to any questions in this section, please explain:

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



III. Past medical history

1. Do you have a history of any of the following? Please circle all that apply.

heart disease hypertension kidney disease thyroid disease migraine headaches

1. Do you have any family history of any of the following? Please circle all that apply.

ear disease neurological disease migraine headache

3. Have you ever suffered a serious head injury or been knocked unconscious? Yes No

4. Do you use tobacco in any form? Yes No

How much?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For how long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Do you use alcohol in any form? Yes No

How much?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of drinks?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How Often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IV. Do you have any of the following symptoms? Circle yes or no and the ear involved.

1. Difficulty in hearing?

Yes No Both ears Right ear Left ear Associated with Attack

1. Noise in your ears?

Yes No Both ears Right ear Left ear Associated with Attack

Describe the noise: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the noise change with dizziness? Yes No

If so, how? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Pain in your ears?

Yes No Both ears Right ear Left ear Associated with Attack

1. Fullness or stuffiness in your ears?

Yes No Both ears Right ear Left ear Associated with Attack

1. Discharge from your ears?

Yes No Both ears Right ear Left ear Associated with Attack

V. Have you experienced any of the following symptoms?

Circle yes or no and if constant or in episodes.

1. Double or blurred vision or blindness? Yes No Constant Episodes

2. Numbness of face? Yes No Constant Episodes

3. Numbness of arms and legs? Yes No Constant Episodes

4. Weakness in arms or legs? Yes No Constant Episodes

5. Clumsiness in arms or legs? Yes No Constant Episodes

6. Confusion or loss of consciousness? Yes No Constant Episodes

7. Difficulty of speech? Yes No Constant Episodes

8. Difficulty with swallowing? Yes No Constant Episodes

9. Pain in neck or shoulder? Yes No Constant Episodes

VI. Please list any other information we may need to know regarding your symptoms:

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

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##### Medications

#### Please list both prescription and over the counter medications

|  |  |  |  |
| --- | --- | --- | --- |
| Drug Name | Dosage | Frequency | Oral/Intravenous/Other |
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Do you use Tobacco Products? Yes No

**Patient Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Clinician Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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**Access to Patient Information**

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To our patients:

Patient privacy laws mandate that our office keep your medical records confidential. These laws also require that we not disclose your medical condition or test results to anyone else without your consent and authorization. Please indicate below if there is any other person who may receive this information.

\*\*\*PLEASE LIST BELOW PERSONS YOU WANT TO HAVE ACCESS TO YOUR MEDICAL RECORDS. THIS INCLUDES PHONE CONTACT AS WELL AS PERSONAL CONTACT   
\*\*\*PLEASE LIST ANY FRIENDS OR RELATIVES THAT MAY BE ASSOCIATED WITH YOUR MEDICAL CARE.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize the staff of Selective Hearing to release confidential information concerning my medical condition (OR MY CHILD IF A MINOR) to the following:

|  |  |  |
| --- | --- | --- |
| Name | Phone Number | Relationship |
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I understand that I may add or remove names from this list, as I deem necessary. I also understand I may revoke any information in writing.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Signature of Patient (or parent/guardian) Date