**WELCOME TO THE OFFICE OF DR. BOCK O.D. P.C.**

We are glad to file your vision and/or medical insurance, but ONLY if all necessary information is provided.

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Which Form of Contact would you prefer for reminders of upcoming appointments?  
 Circle One: EMAIL PHONE POSTCARD

Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(IF NEW PATIENT): How did you hear about us:  
 Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 **INSURANCE INFORMATION:**

Medical Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID# or SS #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vision Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID # or SS # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 First Last Middle

Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (ex: spouse, parent, legal guardian) Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (if different from patient) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State/Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
(Fill in only if patient has 2 different insurances)

Policy Holder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that it is my responsibility to provide the correct insurance information regarding my vision and medical coverage. I give permission for Dr. Juliana Bock O.D. P.C. to use my personal information to obtain insurance authorization for treatment of services. I understand authorization **DOES NOT ALWAYS GUARANTEE PAYMENT** and I am responsible for any remaining charges incurred as well as any additional late, legal, or attorney fees associated with collection.

\*NOTE: Insurance providers require a copay, if applicable, to be collected **each visit**.  
  
  
Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_  
(if patient under 18)

**Juliana Bock O.D., P.C.  
Consent for Treatment, Assignment of Benefits, Financial Policies**

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

* **Consent for Treatment**  
  I authorize Dr. Juliana Bock O.D. to provide treatment to myself and my dependent.
* **Assignment of Benefits**  
  I request that payment of authorized or applicable private insurance benefits be paid directly to Juliana Bock O.D., P.C. for services provided under her care.
* **Financial Responsibility**  
  I understand that Dr. Juliana Bock will file my insurance claim as a courtesy; however, I am ultimately responsible for full payment of all charges. I further understand if my account is referred to a collection agency or attorney I will be responsible for all collection costs including total outstanding indebtedness, accrued interest, late charges and cost of collection. I agree to pay the aforesaid attorney’s fees and cost of collection whether or not the attorney files suit.
* **Release of Medical Information**  
  I authorized Dr. Juliana Bock O.D. to release necessary medical information to my insurance company, its agents, or any third party payer in order for payable benefits for these services to be determined.
* **Referrals/Authorizations**  
  I understand if my insurance company requires a referral, I am responsible for obtaining a referral prior to my visit. If I do not have a referral I will be required to sign a waiver before being seen by the Optometrist and payment in full for services rendered will be collected at check out.
* **Missed Appointments**  
  Missed appointments will be billed a $20.00 “no show” fee. We appreciate at least 24 hours notice if you must cancel an appointment.
* **Returned Checks and Credit Card Payments**  
  Our office will charge $35.00 for any check that is returned for insufficient funds. Credit card returns are subject to service fees and cancelled orders subject to restocking fees.
* **RX Copies/Records Release**  
  Our office will gladly provide you with the original copy of a contact and/or glasses prescription however, additional copies will be billed at $5.00 each. Administrative fees for records release may apply. Please allow up to 48 hours for processing.

I have read the above statements and I understand my responsibilities. A copy of this authorization will be considered as valid as the original.  
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Signature of patient or responsible party Date

**Medical History Questionnaire**  
Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_  
Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Guardian (If Applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Birth Date: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Social Security #: \_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_ Place of Employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Name of Medical Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dr’s Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Eye Exam: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_  
  
Race (circle one): White / Black or African American / Asian / Hispanic or Latino Height: \_\_\_\_\_\_\_\_\_\_\_\_   
 Native Hawaiian / American Indian or Alaskan Native / Other / Prefer not to say Weight: \_\_\_\_\_\_\_\_\_\_\_\_  
Ethnicity(circle one): Hispanic or Latino / Non Hispanic or Latino / Prefer not to say Preferred Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**MEDICAL HISTORY:**  
Do you have any allergies to medications? ⃝ No ⃝ Yes If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_List any medications you take (including oral contraceptives and over-the –counter medications): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
List all major injuries, surgeries and/or hospitalizations you have had: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Circle any of the following that you have had: Crossed Eyes Lazy Eye Drooping Eyelid Prominent Eyes Glaucoma Retinal Disease Cataracts Eye Infections Major Eye Injury  
Are you pregnant and/or nursing? ⃝ No ⃝ Yes  
Do you wear glasses? ⃝ No ⃝ Yes If yes, how old is your present pair: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Do you wear contact lenses? ⃝ No ⃝ Yes if yes, how old is your present pair: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Reason for today’s visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**FAMILY HISTORY:**  
Please note any family history (parents, grandparents, siblings, children, living or deceased) for the following conditions:  
 DISEASE/CONDITION NO YES ? RELATIONSHIP TO YOU (who & maternal/paternal)  
 Blindness ⃝ ⃝ ⃝ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 Cataract ⃝ ⃝ ⃝ ­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 Crossed Eyes ⃝ ⃝ ⃝ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 Glaucoma ⃝ ⃝ ⃝ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 Macular Degeneration ⃝ ⃝ ⃝ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 Retinal Detachment/Disease ⃝ ⃝ ⃝ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 Arthritis ⃝ ⃝ ⃝ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 Cancer (list type) ⃝ ⃝ ⃝ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 Diabetes ⃝ ⃝ ⃝ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 Heart Disease ⃝ ⃝ ⃝ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 High Blood Pressure ⃝ ⃝ ⃝ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 Kidney Disease ⃝ ⃝ ⃝ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 Lupus ⃝ ⃝ ⃝ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 Thyroid ⃝ ⃝ ⃝ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ⃝ ⃝ ⃝ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\* Please turn this form over and complete side two \*\*

**SOCIAL HISTORY:** *This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.* ⃝ Yes, I would prefer to discuss my Social History information directly with my doctor.  
Do you drive? ⃝ No ⃝ Yes   
If yes, do you have visual difficulty when driving? ⃝ No ⃝ Yes   
 If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Do you use tobacco products? ⃝ No ⃝ Yes If yes, type/amount/how long: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Do you drink alcohol? ⃝ No ⃝ Yes If yes, type/amount/how long: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Do you use illegal drugs? ⃝ No ⃝ Yes If yes, type/amount/how long: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Have you ever been exposed to or infected with? ⃝ Gonorrhea ⃝ Hepatitis ⃝ HIV ⃝ Syphilis ⃝ No

**REVIEW OF SYSTEMS:**  
Do you currently have any problems in the following areas:  
**SYSTEM NO YES ? NO YES ?**  
CONSTITUTIONAL EARS, NOSE, MOUTH, THROAT  
 Fever,Weight Loss/Gain ⃝ ⃝ ⃝ Allergies/Hay Fever ⃝ ⃝ ⃝  
INTEGUMENTARY (Skin) ⃝ ⃝ ⃝ Sinus Congestion ⃝ ⃝ ⃝  
NEUROLOGICAL Post-Nasal Drip ⃝ ⃝ ⃝  
 Headaches ⃝ ⃝ ⃝ Chronic Cough ⃝ ⃝ ⃝  
 Migraines ⃝ ⃝ ⃝ Dry Throat/Mouth ⃝ ⃝ ⃝  
 Seizures ⃝ ⃝ ⃝ RESPIRATORY  
EYES Asthma ⃝ ⃝ ⃝  
 Loss of Vision ⃝ ⃝ ⃝ Chronic Bronchitis ⃝ ⃝ ⃝  
 Blurred Vision ⃝ ⃝ ⃝ Emphysema ⃝ ⃝ ⃝  
 Distorted Vision/Halos ⃝ ⃝ ⃝ VASCULAR / CARDIOVASCULAR  
 Double Vision ⃝ ⃝ ⃝ Diabetes ⃝ ⃝ ⃝  
 Dryness ⃝ ⃝ ⃝ Heart Pain ⃝ ⃝ ⃝  
 Mucous Discharge ⃝ ⃝ ⃝ High Blood Pressure ⃝ ⃝ ⃝  
 Redness ⃝ ⃝ ⃝ Vascular Disease ⃝ ⃝ ⃝ Sandy/Gritty Feeling ⃝ ⃝ ⃝ GASTROINTESTINAL  
 Itching ⃝ ⃝ ⃝ Diarrhea ⃝ ⃝ ⃝ Burning ⃝ ⃝ ⃝ Constipation ⃝ ⃝ ⃝  
 Foreign Body Sensation ⃝ ⃝ ⃝ GENITOURINARY  
 Excess Tearing/ Watering ⃝ ⃝ ⃝ Genitals/Kidney/Bladder ⃝ ⃝ ⃝ Glare/Light Sensitivity ⃝ ⃝ ⃝ BONES / JOINTS / MUSCLES  
 Eye Pain or Soreness ⃝ ⃝ ⃝ Arthritis ⃝ ⃝ ⃝  
 Chronic Infection of Eye/Lid ⃝ ⃝ ⃝ Muscle Pain ⃝ ⃝ ⃝  
 Sties or Chalazion ⃝ ⃝ ⃝ Joint Pain ⃝ ⃝ ⃝  
 Flashes/Floaters in Vision ⃝ ⃝ ⃝ LYMPHATIC / HEMATOLOGIC  
 Tired Eyes ⃝ ⃝ ⃝ Anemia ⃝ ⃝ ⃝  
ENDOCRINE ALLERGIC / IMMUNOLOGIC ⃝ ⃝ ⃝  
 Thyroid/ Other Glands ⃝ ⃝ ⃝ PSYCHIATRIC   
 Elevated Cholesterol ⃝ ⃝ ⃝ Depression/Anxiety ⃝ ⃝ ⃝

If you answered YES to any of the above or have a condition not listed, please explain briefly:  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
DOCTOR’S SIGNATURE Date