Senior Health Clinic
Washington Regional

We specialize in the care of Parkinson's disease and other movement disorders. We use a team approach to your care and Nurse Practitioners are an integral part of your team. You will typically see one of them in-between your visits with Dr. Diamond.

Our office hours are from 8:00 a.m. to 4:00 p.m. Monday through Thursday, and Friday's 8:00 a.m. to 12:00 p.m. If you need an urgent appointment you may either see your doctor or a Nurse Practitioner. If you need to reschedule your appointment, please notify us 24-48 hours ahead of time.

The best way to contact your team or physician is to call 479-463-4444 and ask for your doctor's nurse or use the patient portal for questions. Our nurses check messages throughout the day and will forward them to your doctor if they can't answer them.

Please make your follow up appointments at the check-out desk before you leave our office. We look forward to working with you.

Sincerely,
Parkinson's and Movement Disorders Clinic

Alan Diamond, DO Heather Terry, APRN Walker Dyer, APRN

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Patient Demographic Information:

Last name _____ First name _____ Middle initial _____

Street address _____ City _____ State _____ Zip code _____

Age _____ DOB ____/____/____ SSN _____-____-_____ Sex: Male _____ Female _____

Occupation _____ Employer _____ Full Time/Part-time

Is patient a Veteran: **YES / NO** Is patient Retired: **YES / NO** Date of Retirement _____

Primary Phone # _____ Alternate Phone # _____

Marital status: Married _____ Single _____ Partner _____ Divorced _____ Widowed _____ Separated _____

Ethnicity (Origin): Not Hispanic or Latino _____ Hispanic or Latino _____ Other _____ Decline _____

Race: _____ Preferred Language: _____

Email address _____

Preferred method of communication: Cellphone _____ Home Phone _____ Email _____

Preferred Pharmacy _____

Guarantor Information:

Is the patient the guarantor? Yes _____ No _____ (If yes please leave the remainder of this section blank)

Last name _____ First name _____ Middle initial _____

Street address _____ City _____ State _____ Zip code _____

Age _____ DOB ____/____/____ SSN _____-____-_____ Sex: Male _____ Female _____

Occupation _____ Employer _____

Primary Phone# _____ Alternate Phone# _____

Patient signature _____

If patient is unable to sign, Power of Attorney document must be provided authorizing the above named as a legal guarantor

Please list all individuals who may have access to the patient's personal health information:

Name _____ Relationship to patient _____ Phone# _____

Name _____ Relationship to patient _____ Phone# _____

Name _____ Relationship to patient _____ Phone# _____

Who should we contact in case of an emergency?

Last name _____ First name _____ DOB ____/____/____

SSN _____-____-_____ Sex: Male _____ Female _____ Relationship to patient _____

Primary Phone # _____ Employer _____

I certify that the above information is accurate.

Authorized guarantor signature _____ **Date** _____

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Primary Insurance

Patient's relationship to the Main Policy Holder: Myself _____ Spouse _____ Other _____

Insurance ID # _____

Name of Insurance Company _____

Insurance Company Address _____

City _____ State _____ Zip code _____

Insurance Company's Phone Number _____

Main Holder's Name _____ Main Holder's Date of Birth _____

Main Holder's Address _____ Main Holder's SSN _____

City _____ State _____ Zip code _____

Secondary Insurance

Patient's relationship to the Main Policy Holder: Myself _____ Spouse _____ Other _____

Insurance ID # _____

Name of Insurance Company _____

Insurance Company Address _____

City _____ State _____ Zip code _____

Insurance Company's Phone Number _____

Main Holder's Name _____ Main Holder's Date of Birth _____

Main Holder's Address _____ Main Holder's SSN _____

City _____ State _____ Zip code _____

Other Information:

Name of person filling out this form: _____

Relation to Patient _____ How did you hear about this clinic _____

Current primary care doctor _____ Last visit with primary doctor _____

Comments or concerns about patient's health:

_____

List Primary Care Physician and Specialist

Name	Address

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Medical History

Do you have any of the following?	Yes	No	Comments
Diabetes			
High Blood Pressure			
Stroke			
Memory Problems			
Cancer			
Emphysema			
Kidney Disease			
Pneumonia			
Arthritis			
Osteoporosis/Broken Bones			
Other (please list)			

What Surgeries Have You Had:

Type and Location (i.e. left or right)	Date	Hospital

List All Hospitalizations Within the Last Five Years:

Hospital	Reason	When

Psychiatric History

Have you had any nervous or psychiatric illness? Please list illness.	Yes	No	Comments

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Current Medications: Please Bring All Your Medication with You

Medication Name	How much do take at each dose?	When do I take it?	Why do I take it?

Allergies

Medication	Food	Reaction

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Health Maintenance:

	Date	Yes	No	Comments
When was our last eye exam?				
When was our last dental exam?				
When was our last Tetanus shot?				
Have you taken the Pneumovax 23 vaccine?				
Have you taken Prevnar 13?				
Have you taken the Zostavax vaccine? (shingles)				
Do you take the yearly Flu shot?				
Has your stool been checked for blood?				
Have you had a sigmoidoscopy or colonoscopy?				Results:
Has your cholesterol been checked?				
Do you engage in any exercise? Type?				
Do you follow any special diets?				
Has your bone density been measured?				
FOR WOMEN				
When was your last mammogram/breast examination?				
When was our last pelvic exam/ pap smear?				
Have you ever taken hormones i.e. estrogen?				
FOR MEN				
When was your last prostate exam?				

Overall Health:

How do you feel? (check one)	Excellent	Good	Fair	Poor

Family History

Please list current age and health status of family members deceased list a date death and cause	
Mother	
Father	
Brother (s)	
Sister(s)	
Spouse	
Children	

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Social History

Education (highest grade completed)	
Work history /former occupation	
Are you retired?	Month/Year:
What are your current activities?	
What is your current living situation?	Type of House: With whom?
Have any friends or relatives died recently?	
Are you having any severe financial difficulty?	
Do you currently have home health?	Yes _____ No _____ Name of Company _____
Are you a caregiver to anyone in home/family?	
Do you smoke cigarettes or use tobacco?	Yes _____ No _____ Past years, but quit:
Do you drink alcohol, including beer, wine, or other alcohol?	Type: _____ Current Former
If you drink alcohol, has anyone ever been concerned about your drinking?	

Functional Assessment:

Do you have any problems with	Yes	No	Comments
Walking			
Leakage of urine or bowel incontinence			
Bathing yourself			
Feeding yourself			
Getting out of bed or chair			
Using the telephone			
Driving a car			
Using public transportation			
Doing your own shopping			
Doing your own cooking			
Doing your own cleaning			
Managing your own finances			
Taking your medications			
Have you fallen or experienced falls?			If yes, what were the circumstances of the fall? _____ Did you pass out or lose consciousness? _____Yes _____ No
Do you use assistive device(s)?			Cane ___Crutches ___Walker ___Dentures ___Prosthetic limb ___ Hearing aid ___Splint/Brace ___Glasses ___Contacts ___ Wheelchair ____CPAP ___Medical Implants___

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Advance Directives:

(Use back of sheet if needed)	Yes	No	Comments
Have you appointed a durable power of attorney for health care decisions?			
Do you have a living will?			
If you were unable to make your own health care decisions, who would you trust to make these decisions on our behalf?			Name _____ Relationship _____ Address _____ Phone# _____
Do you have any opinions about cardiac resuscitation, mechanical ventilation, feeding tubes, or other medical interventions that our doctor should know about?			

Please bring in a copy of your Living Will, Advance Directive, or Power of Attorney/Guardianship paperwork if available.

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Our clinic participates in a special Medicare Program for older adults. This program ensures we adhere to recognized and best practice protocols for the care of older adults. This program has guidelines for prescription medications, primarily those associated with poor outcomes in older adults.
We DO NOT prescribe certain classes of medications. The following medications are examples of medications we do not prescribe, for long term use.

Chronic Pain Medications and Muscle Relaxants: Opioids such as Fentanyl (Actiq, Duragesic, Fentora), Hydrocodone (Hysingla ER, Zohydro ER), Hydrocodone/Acetaminophen (Lorcet, Lortab, Norco, Vicodin), Hydromorphone (Dilaudid, Exalgo), Meperidine (Demerol), Methadone (Dolophine, Methadose), Morphone (Astramorph, Avinza, Kadian, MS Contin, Ora-Morph SR), Oxycodone (Percocet, Endocet, OxyContin, Oxecta, Roxicodone), Morphine (MS Contin), and/or muscle relaxers such as Carisoprodol (Soma).

Anxiety/Panic/Adult ADD/ADHD: Benzodiazepines such as Alprazolam (Niravam, Xanax, Xanax XR), Chlordiazepoxide (Librax), Clobazam (Onfi), Clonazepam (Klonopin), Clorazepate (Tranxene T-Tab), Diazepam (Valium), Estazolam (ProSom), Flurazepam (Dalmane), Lorazepam (Ativan), Midazoam (Versed), Oxazepam (Serax), Temazepam (Restoril), Triazolam (Halcion), Methyphenidate (Concerta, Ritalin, Daytana, Metadate CD, Methylin), Dextroamphetamine/Amphetamine (Adderall), Lisdexamfetamine (Vyvanse) or Mixed Salts Amphetamine (Adderall).

Weight Loss/Weight Gain Medications: Phentermine (Adipex-P), Megace (megestrol acetate), or Periactin

Narcolepsy/Sleep Apnea: Armodafinil (Nuvigil) or Modanfinil (Provigil)

Sleeping Aids or Sedatives: Ambien (Zolpidem), Lunesta (Eszopiclone), Sonata (Zaleplon), or Doxepin

I have read and understand the above agreement prior to seeing the physician 's and providers at the Washington Regional Pat Walker Center for Senior 's by signing below, I am verifying that I would like to be a patient of the Washington Regional Pat Walker Center for Senior 's and that I understand My doctor ***will not*** *be prescribing or refilling any of the above medications. I agree that if I need such medications, I, will need to find another physician for treatment or agree to see a specialist who can prescribe the medication(s).*

_____
Print Patient Name

_____
Patient Signature Date

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WHAT TO EXPECT NEXT

- The new patient packet must be received within24 hours before your appointment or it will be rescheduled.
- Please be aware that your appointment can last up to 2 hours.
- You must bring all medications except for refrigerated medications.
- Insurance cards are required at the time of check-in.
- All appointments must be confirmed at least a day before or you may run the risk being cancelled.

CANCELLATION POLICY/ NO SHOW POLICY

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel or do not show to your appointment, you may be preventing another patient from getting needed treatment. Appointments are in high demand your early cancellation is greatly appreciated.

Due to an exceedingly "full" appointment book, we require at least 24-hour notice to cancel or reschedule an appointment. If a cancellation occurs within 24 hours of an appointment, the patient will be recorded as a "No Show". If proper notice is not given ***two times***, you will receive a verbal warning about the possibility of being discharged from our practice for failure to follow this policy a third time.
Failure to be present at the time for a scheduled appointment will be recorded in your medical record as a "No Show". This could potentially cause you to be discharged from our practice.

This policy enables us to better utilize available appointments for our patients in need of medical care.

New Patients will not be allowed to reschedule a No-Show appointment, or if the appointment has been rescheduled twice.

Please call 479-463-4444 if you wish to reschedule. You may leave a detailed message on our voicemail, please leave your name, date of birth and a good call back number. We will return your call and give you the next available appointment time.

I have read and agree with the above Cancellation Policy.

Signed: _____ Date: _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

REM Sleep Behavior Disorder Screening Questionnaire

Please answer each question by circling either "YES" or "NO"

Yes **No** I sometimes have vivid dreams.

Yes **No** My dreams frequently have an aggressive or action-packed content.

Yes **No** The dream contents mostly match my nocturnal behavior.

Yes **No** I know that my arms and legs move when I sleep.

Yes **No** It thereby happened that I (almost) hurt my bed partner or myself.

I have had the following phenomenon during my dreams:

Yes **No** speaking, shouting, swearing, laughing loudly

Yes **No** sudden limb movements, "fights"

Yes **No** gestures, complex movements, that are useless during sleep, e.g. to wave, to salute, to frighten mosquitoes, falls of the bed.

Yes **No** things that fell down around the bed, e.g. bedside lamp, book, glasses

Yes **No** It happens that my movements awake me.

Yes **No** After awakening I mostly remember the content of my dreams well.

Yes **No** My sleep is frequently disturbed.

Yes **No** I have had a disease of the nervous system (e.g. stroke, head trauma, parkinsonism, RLS, narcolepsy, depression, epilepsy, inflammatory disease of the brain.)

SCORING

Maximum score is 13

Cut of score of 5 or above

The Epworth Sleepiness Scale

The Epworth Sleepiness Scale is widely used in the field of sleep medicine as a subjective measure of a patient's sleepiness. The test is a list of eight situations in which you rate your tendency to become sleepy on a scale of 0, no chance of dozing, to 3, high chance of dozing. When you finish the test, add up the values of your responses. Your total score is based on a scale of 0 to 24. The scale estimates whether you are experiencing excessive sleepiness that possibly requires medical attention.

How Sleepy Are You?
How likely are you to doze off or fall asleep in the following situations? You should rate your chances of dozing off, not just feeling tired. Even if you have not done some of these things recently try to determine how they would have affected you. For each situation, decide whether or not you would have:

- No chance of dozing =0
- Slight chance of dozing =1
- Moderate chance of dozing =2
- High chance of dozing =3

Write down the number corresponding to your choice in the right hand column. Total your score below.

Situation	Chance of Dozing
Sitting and reading	•
Watching TV	•
Sitting inactive in a public place (e.g., a theater or a meeting)	•
As a passenger in a car for an hour without a break	•
Lying down to rest in the afternoon when circumstances permit	•
Sitting and talking to someone	•
Sitting quietly after a lunch without alcohol	•
In a car, while stopped for a few minutes in traffic	•

Total Score = _____

Analyze Your Score

Interpretation:

0-7: It is unlikely that you are abnormally sleepy.
8-9: You have an average amount of daytime sleepiness.
10-15: You may be excessively sleepy depending on the situation. You may want to consider seeking medical attention.
16-24: You are excessively sleepy and should consider seeking medical attention.

Reference: Johns MW. A new method for measuring daytime sleepiness: The Epworth Sleepiness Scale. *Sleep* 1991; 14(6):540-5.

Non-motor symptoms questionnaire

Parkinson's Disease Society

Name: ..... Date: ..... Age: .....

Centre ID: Male ☐ Female ☐

Non-movement problems in Parkinson's

The movement symptoms of Parkinson's are well known. However, other problems can sometimes occur as part of the condition or its treatment. It is important that the doctor knows about these, particularly if they are troublesome for you.

A range of problems is listed below. Please tick the box 'Yes' if you have experienced it during the past month. The doctor or nurse may ask you some questions to help decide. If you have not experienced the problem in the past month tick the 'No' box. You should answer 'No' even if you have had the problem in the past but not in the past month.

Have you experienced any of the following in the last month?

		Yes	No
1	Dribbling of saliva during the daytime.	☐	☐
2	Loss or change in your ability to taste or smell.	☐	☐
3	Difficulty swallowing food or drink or problems with choking.	☐	☐
4	Vomiting or feelings of sickness (nausea).	☐	☐
5	Constipation (less than three bowel movements a week) or having to strain to pass a stool.	☐	☐
6	Bowel (faecal) incontinence.	☐	☐
7	Feeling that your bowel emptying is incomplete after having been to the toilet.	☐	☐
8	A sense of urgency to pass urine makes you rush to the toilet.	☐	☐
9	Getting up regularly at night to pass urine.	☐	☐
10	Unexplained pains (not due to known conditions such as arthritis).	☐	☐
11	Unexplained change in weight (not due to change in diet).	☐	☐
12	Problems remembering things that have happened recently or forgetting to do things.	☐	☐
13	Loss of interest in what is happening around you or in doing things.	☐	☐
14	Seeing or hearing things that you know or are told are not there.	☐	☐
15	Difficulty concentrating or staying focussed.	☐	☐
16	Feeling sad, 'low' or 'blue'.	☐	☐
17	Feeling anxious, frightened or panicky.	☐	☐
18	Feeling less interested in sex or more interested in sex.	☐	☐
19	Finding it difficult to have sex when you try.	☐	☐
20	Feeling light-headed, dizzy or weak standing from sitting or lying.	☐	☐
21	Falling.	☐	☐
22	Finding it difficult to stay awake during activities such as working, driving or eating.	☐	☐
23	Difficulty getting to sleep at night or staying asleep at night.	☐	☐
24	Intense, vivid or frightening dreams.	☐	☐
25	Talking or moving about in your sleep, as if you are 'acting out' a dream.	☐	☐
26	Unpleasant sensations in your legs at night or while resting, and a feeling that you need to move.	☐	☐
27	Swelling of the legs.	☐	☐
28	Excessive sweating.	☐	☐
29	Double vision.	☐	☐
30	Believing things are happening to you that other people say are not.	☐	☐

All the information you supply through this form will be treated with confidence and will only be used for the purpose for which it has been collected. Information supplied will be used for monitoring purposes. Your personal data will be processed and held in accordance with the Data Protection Act 1998. Developed and validated by the International PD Non Motor Group.

Code B117

Caregiver Strain Index (CSI)

I am going to read a list of things that other people have found to be difficult. ***Would you tell me whether any of these apply to you?*** (GIVE EXAMPLES)

	Yes = 1	No = 0
Sleep is disturbed (e.g., because . . . is in and out of bed or wanders around at night)		
It is inconvenient (e.g., because helping takes so much time or it's a long drive over to help)		
It is a physical strain (e.g., because of lifting in and out of a chair; effort or concentration is required)		
It is confining (e.g., helping restricts free time or cannot go visiting)		
There have been family adjustments (e.g., because helping has disrupted routine; there has been no privacy)		
There have been changes in personal plans (e.g., had to turn down a job; could not go on vacation)		
There have been emotional adjustments (e.g., because of severe arguments)		
Some behavior is upsetting (e.g., because of incontinence; . . . has trouble remembering things; or . . . accuses people of taking things)		
It is upsetting to find . . . has changed so much from his/her former self (e.g., he/she is a different person than he/she used to be)		
There have been work adjustments (e.g., because of having to take time off)		
It is a financial strain		
Feeling completely overwhelmed (e.g., because of worry about . . . ; concerns about how you will manage)		
Total Score (Count yes responses. Any positive answer may indicate a need for intervention in that area. A score of 7 or higher indicates a high level of stress.)		

Robinson, B. (1983). Validation of a Caregiver Strain Index. *Journal of Gerontology*. 38:344-348.

PATIENT NAME: _____ DATE OF BIRTH: _____

MEDICARE SECONDARY PAYER QUESTIONNAIRE

PART I

A. Information about Black Lung (BL), Workers' Compensation (WC), No-Fault and Liability

1. Are you receiving Black Lung (BL) benefits? ☐ Yes ☐ No
2. If yes, date Black Lung benefits began? _____

NOTE: BL IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO BL

3. Are today's services due to an illness/injury from a work-related accident/condition through Workers' Compensation (WC)? ☐ Yes ☐ No
4. **If yes, please complete below**:

Employer Name: _____
Employer Address: _____
Insurance Carrier Name: _____
Insurance Carrier Address: _____
City/State/Zip: _____
Insurance Policy or Claim number: _____
Date of illness/injury: _____

NOTE: WC IS PRIMARY PAYER ONLY FOR WORK-RELATED ILLNESS/INJUIRES

5. Are you receiving treatment for an illness or injury covered under no-fault (and/or medical-payment coverage) including premises or automobile? ☐ Yes ☐ No
6. **If yes, please complete below**:

Insurance Carrier Name: _____
Insurance Carrier Address: _____
Insurance Policy or Claim number: _____
Date of illness/injury: _____

NOTE: NO-FAULT INSURANCE IS PRIMARY PAYER ONLY FOR SERVICES RELATED TO ACCIDENT

7. Are you receiving treatment for an illness or injury for which another party may be liable? ☐ Yes ☐ No
8. **If yes, please complete below**:

Insurance Carrier Name: _____
Insurance Carrier Address: _____
City/State/Zip: _____
Insurance Policy or Claim number: _____
Date of illness/injury: _____

NOTE: LIABILITY INSURANCE IS PRIMARY PAYER ONLY FOR SERVICES RELATED TO LIABILITY

PART II

A. Information about Medicare Entitlement and Group Health Plans

1. Are you entitled to Medicare based on: ☐ Age ☐ Age and ESRD ☐ Disability ☐ Disability and ESRD ☐ End Stage Renal Disease (ESRD)
2. Do you have group health plan (GHP) coverage based on your own current employment, or the current employment of a spouse or another family member? ☐ Yes ☐ No

If yes, the employer GHP may be primary to Medicare. Continue to #3. If no, **stop here.**

PATIENT NAME: _____ DATE OF BIRTH: _____

3. How many employees, including yourself or spouse, work for the employer from who you have GHP coverage? ☐ 1-19 ☐ 20-99 ☐ 100+

NOTE: IF THERE ARE MORE THAN 20, THE GHP WILL BE PRIMARY. UNDER 20, MCR PRIMARY. IF YOU ARE DISABLED AND THE GHP EMPLOYER HAS 100+ EMPLOYEES, GHP IS PRIMARY.

4. Group Health Plan (GHP) information required to submit claims properly:

GHP Name: _____
GHP Address: _____
City/State/Zip: _____
Policy Number: _____ Group Number: _____
Date Coverage Began: _____ Name of Policy Holder: _____
Relationship to Patient: ☐ self ☐ spouse ☐ other: _____

PART III

A. Information about the Patient if ESRD Medicare Entitlement Applies (including Dual Entitlement)

1. Do you have employer group health plan (GHP) coverage through yourself, a spouse, or family member if dually entitled based on Disability and ESRD? ☐ Yes ☐ No

IF YES, THE EMPLOYER GHP MAY BE PRIMARY TO MEDICARE. CONTINUE BELOW.

2. Have you received a kidney transplant? ☐ Yes ☐ No
   Date of transplant: _____
3. Have you received maintenance dialysis treatments? ☐ Yes ☐ No
   Date dialysis began: _____
4. Are you within the 30-month coordination period? ☐ Yes ☐ No

NOTE: THE 30-MONTH COORDINATOR PERIOD STARTS THE FIRST DAY OF THE MONTH AN INDIVIDUAL IS ELIGIBLE FOR MEDICARE (EVEN IF NOT YET ENROLLED IN MEDICARE) BECAUSE OF KIDNEY FAILURE (USUALLY THE 4TH MONTH OF DIALYSIS) REGARDLESS OF ENTITLEMENT DUE TO AGE OR DISABILITY. IF THE INDIVIDUAL IS PARTICIPATING IN A SELF-DIALYSIS PROGRAM OR HAD A KIDNEY TRANSPLANT DURING THE 3-MONTH WAITING PERIOD, THE 30-MONTH COORDINATION PERIOD STARTS WITH THE FIRST DAY OF THE MONTH OF DIALYSIS OR KIDNEY TRANSPLANT.

5. Were you receiving GHP coverage prior to and on the date of Medicare entitlement due to ESRD (or simultaneous entitlement due to ERSD and Age or ESRD and Disability)?
   ☐ Yes ☐ No

NOTE: IF YES, THE GHP IS PRIMARY DURING THE 30-MONTH COORDINATION PERIOD

6. The following information is necessary to submit claims appropriately:

Employer Name: _____
Employer Address: _____
Insurance Carrier Name: _____
Insurance Carrier Address: _____
City/State/Zip: _____
Policy Number: _____ Group Number: _____
Date Coverage Began: _____ Name of Policy Holder: _____
Relationship to Patient: ☐ self ☐ spouse ☐ other: _____