

CASPER ORTHOPAEDIC ASSOCIATES, PC



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### Office Information

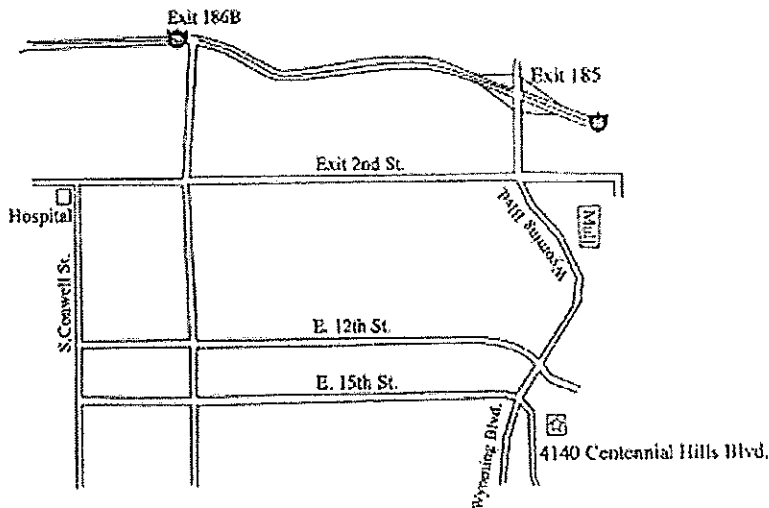
[Notice of Privacy Practices](#)

**Office Location**  
 4140 Centennial Hills Blvd.  
 Suite A  
 Casper, WY 82609

T 307.265.7205  
 F 307.235.6262  
 Toll Free 1.888.317.2343

**Office Hours**  
 8:00am - 5:00pm  
 Monday - Friday

**Insurance Information**  
 We file with most major insurance plans. Complete paperwork is required before filing with any insurance company.



### Appointments

Appointments for routine office visits may be made during regular office hours by calling 307.265.7205 or 1.888.317.2343. Please do not call on weekends to schedule a routine appointment.

We believe your time is valuable. While we endeavor to keep scheduled appointments, sometimes on emergency occurs. We will inform you when your doctor is unable to keep the appointment or is going to be significantly delayed and we will ask your preference in rescheduling.

### Forms

- [Patient Information Form](#)
- [Medical History Form](#)
- [Assignment of Insurance Benefits](#)
- [Arbitration Agreement](#)



### Telephone

If you have a question or problem that needs the attention of your orthopaedic surgeon, please call during office hours. Since it is not always practical for us to interrupt the doctor during patient exams, you are asked to relay your message and/or problem to one of our staff. Your call will be answered as soon as possible, usually by the close of office hours.

After office hours, calls made to the office will automatically reach our answering service and will be directed to the physician on call.

### Prescriptions & Renewals

**TWENTY FOUR Hour Notification**  
 Prescriptions and medication refills are issued during office hours only (before noon on Fridays). For a prescription refill, please call the pharmacy first and let them contact us. Please remember to check your need for medicine prior to weekends and holidays. The physician on call for the weekend will not refill

narcotic prescriptions. We ask for twenty-four-hour notification of refills/ 48 hours for narcotic medication refills.

#### **Confidentiality (72 hour notification)**

Your medical records are confidential, so it is necessary for you to sign a release before we may send information to you or to any insurance company, attorney or other parties. Before we may release any information to your attorney we must have a written request from him/her. The fee for copying records varies.

X-rays are the property of the physician who has taken them and are retained as part of the patient's medical record. You may receive copies of your x-rays that have been taken in our office for a small fee. You will be notified of that cost before copies are made.

It is very important that the office be given a 72-hour notice to prepare your copies for you.

#### **Surgery/Precertification**

If you require surgery, our office staff will assist you with the necessary paperwork and arrangements. This can be a lengthy process and we thank you for your patience. If you have any questions after leaving the office, please don't hesitate to call for clarification.

Your insurance company may require pre-certification for surgery. It is your responsibility to contact your insurance company to begin the pre-certification process if it is required. If your insurance company requires additional medical information, they will need to contact our office.

***Failure to pre-certify with your insurance may result in a decreased payment and/or denial of your claim leaving you responsible for payment on all surgery charges.***

Some surgical procedures require a surgical assistant. If an assistant surgeon is used, an estimate of their fee is normally 20% of the surgeon's fee.

#### **Fees & Payments**

We make every effort to decrease the cost of your medical care. Therefore, we request payment arrangements for a office services at the time they are rendered unless prior arrangements have been made. We accept cash, checks, MasterCard, and Visa, for your convenience. As a courtesy we are willing to file a claim with your insurance once we receive the completed paperwork in our office. However, payment is the patient's responsibility. Employees are available to assist you with insurance billing and other payment options. Please feel free to speak with them regarding your account.

#### **Disability Insurance**

If you have insurance which pays income, or house/car/credit card payments when you are disabled, there may be forms we need to complete. You are responsible for getting these forms to our office in adequate time for completion (7 working days). There is a charge to complete each form. If this procedure is followed, your claim will be processed quickly and as a result, you will receive your benefits in a timely manner.

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Wyoming Surgical Center, LLC | Wyoming Orthopaedic & Sports Therapy Center | Casper Orthopaedic Associates, PC

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Last Modified: August 8, 2006

# Privacy Policy

Casper Orthopaedic Associates, P.C. Privacy Notice – Effective November 1, 2002

*This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.*

We understand that the privacy of your personal information is important to you. As your physicians, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and procedures. Should you have any questions regarding these policies, please do not hesitate to ask our privacy officer who can be reached at (307) 265-7205.

## *Information We Collect About You*

We collect personal information about you and your family as part of our registration process, during the course of your care and from other health care entities you utilize such as hospitals, laboratories, other physicians, imaging facilities and your insurance company. This personal information includes items such as your name, address, phone number, birth date, social security number, employer, health history, insurance policy and coverage information. During the course of your treatment, we will collect health information regarding diagnosis, treatment plans, progress and any test results or films.

## *How Your Information Is Used*

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment or routine health care operations. This means we may send your information to other physicians or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of your information require a signed authorization by you, the patient or guardian. Casper Orthopaedic Associates, P.C. does not sell patient information. In certain cases of public health interest we may be required to disclose certain information to local, state or national health organizations or government agencies.

## *Safeguarding Your Personal and Health Information*

We are required by law to (1) make sure that medical information that identifies you is kept private (2) provide you with our privacy policy (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide quality service to you. Casper Orthopaedic Associates, P.C. maintains physical, electronic and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated you have the right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment with Casper Orthopaedic Associates, P.C.

## *Changes To Our Privacy Policy*

All new patients will receive a copy of our privacy policy. Casper Orthopaedic Associates, P.C. occasionally reviews its privacy policy and reserves the right to amend it. Notification of changes will be available at the front desk prior to the effective date of any changes.

## *Your Right To Restrict Use Of Information*

You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed, it will remain in effect until you request a change.

## BINDING ARBITRATION STATEMENT

In an attempt to resolve any claims of malpractice fairly and quickly, Casper Orthopaedic Associates, PC and the Wyoming Surgical Center and its associates are instituting a Binding Arbitration Agreement, hereafter called "agreement." We will use this agreement to address any major concerns and claims that you may have regarding your care. The crisis in availability and cost of professional liability insurances requires us to do this.

This agreement will help you keep your physician in Wyoming. Our main goal is to take care of our patients. Recruitment and retention of physicians in Casper is a problem and will continue to be a problem in the near future.

Should a claim need to be filed, this process will allow faster handling of the claim and allow both parties to discuss the problem in a neutral atmosphere that is less antagonistic and formal than in a court of law. It should minimize the costs of claims for both the patient and the healthcare provider. It **does not** jeopardize your ability to have a concern addressed in an impartial setting.

Feel free to discuss this agreement with our office personnel; however, **we require this agreement to be signed in order to treat you.**

**ARBITRATION AGREEMENT**  
**CASPER ORTHOPAEDIC ASSOCIATES, P.C.**

**ARTICLE 1 Dispute Resolution**

By signing this Agreement ("Agreement") we are agreeing to resolve any Claim for medical malpractice by the dispute resolution process described in this Agreement. Under this Agreement, you can pursue your Claim and seek damages, but you are waiving your right to have it decided by a judge or jury.

**ARTICLE 2 Definitions**

- A. The term "we," "parties," or "us" means you, (the Patient), and the provider.
- B. The term "Claim" means one or more Malpractice Actions as defined under Wyoming law.
- C. The term "Provider" means the physician, group or Casper Orthopaedics, and their employees, partners, associates, and agents.
- D. The term "Patient" or "you" means:
  - (1) you and any person who makes a Claim for care given to YOU, such as your heirs, your spouse, children, parents, or legal representatives.

**ARTICLE 3 Dispute Resolution Options**

- A. Methods Available for Dispute Resolution. We agree to resolve any Claim by:
  - (1) working directly with each other to try and find a solution that resolves the Claim, OR
  - (2) using non-binding mediation (each of us will bear one-half of the costs); OR
  - (3) using binding arbitration as described in this Agreement.

**YOU MAY CHOOSE TO USE ANY OR ALL OF THESE METHODS TO RESOLVE YOUR CLAIM**

- B. Legal Counsel. Each of us may choose to be represented by legal counsel during any stage of the dispute resolution process, but each of us will pay the fees and costs of our own attorney.
- C. Arbitration – Final Resolution. If working with the Provider or using nonbinding mediation does not resolve your Claim, we agree that your Claim will be resolved through binding arbitration. We both agree that the decision reached in binding arbitration will be final.

**ARTICLE 4 How to Arbitrate a Claim**

- A. Notice. To make a Claim under this Agreement, mail a written notice to the Provider by certified mail that briefly describes the nature of your Claim (the "Notice"). If the Notice is sent to the Provider by certified mail it will suspend (toll) the applicable statute of limitations during the dispute resolution process described in this Agreement.
- B. Arbitrators. Within 30 days of receiving the Notice, the Provider will contact you. If you and the Provider cannot resolve the Claim by working together or through mediation, we will start the process of choosing arbitrators. There will be three arbitrators, unless we agree that a single arbitrator may resolve the Claim.
  - (1) Appointed Arbitrators. You will appoint an arbitrator of your choosing and all Providers will jointly appoint an arbitrator of their choosing.

(2) Jointly-Selected Arbitrator. You and the Provider(s) will then jointly appoint an arbitrator (the "Jointly-Selected Arbitrator"). If you and the Provider(s) cannot agree upon a Jointly-Selected Arbitrator, the arbitrators appointed by each of the parties will choose the Jointly-Selected Arbitrator from a list of individuals approved as arbitrators by the state or federal court of Wyoming. If the arbitrators cannot agree on a Jointly-Selected Arbitrator, either or both of us may request that a Wyoming court select an individual from the lists described above. Each party will pay their own fees and costs in such an action. The Jointly-Selected Arbitrator will preside over the arbitration hearing and have all other powers of an arbitrator as set forth in the Wyoming Uniform Arbitration Act.

- C. Arbitration Expenses. You will pay the fees and costs of the arbitrator you appoint and the Provider(s) will pay the fees and costs of the arbitrator the Provider(s) appoints. Each of us will also pay one-half of the fees and expenses of the Jointly-Selected Arbitrator and any other expenses of the arbitration panel.
- D. Final and Binding Decision. A majority of the three arbitrators will make a final decision on the Claim. The decision shall be consistent with the Wyoming Uniform Arbitration Act.
- E. All Claims May Be Joined. Any person or entity that could be appropriately named in a court proceeding ("Joined Party") is entitled to participate in this arbitration as long as that person or entity agrees to be bound by the arbitration decision ("Joinder"). This includes consulting, assisting, or referral physicians utilized by Casper Orthopaedics, including, but not limited to anesthesiologists, pathologists, and other subspecialists. Joinder may also include Claims against persons or entities that provided care prior to the signing date of this Agreement. A "Joined Party" does not participate in the selection of the arbitrators but is considered a "Provider" for all other purposes of this Agreement.

#### **ARTICLE 5 Liability and Damages May Be Arbitrated Separately**

At the request of either party, the issues of liability and damages will be arbitrated separately. If the arbitration panel finds liability, the parties may agree to either continue to arbitrate damages with the initial panel or either party may cause that a second panel be selected for considering damages. However, if a second panel is selected, the Jointly Selected arbitrator will remain the same and will continue to preside over the arbitration unless the parties agree otherwise.

#### **ARTICLE 6 Venue / Governing Law**

The arbitration hearings will be held in a place agreed to by the parties. If the parties cannot agree, the hearings will be held in Casper, Wyoming. Arbitration proceedings are private and shall be kept confidential. The provisions of the Wyoming Uniform Arbitration govern this Agreement. We hereby waive the pre-litigation panel review requirements of Wyoming Statute. The arbitrators will apportion fault to all persons or entities that contributed to the injury claimed by the Patient, whether or not those persons or entities are parties to the arbitration.

#### **ARTICLE 7 Term / Rescission / Termination**

- A. Term. This Agreement is binding on both of us for one year from the date you sign it unless you rescind it. If it is not rescinded, it will automatically renew every year unless either party notifies the other in writing of a decision to terminate it.
- B. Rescission. You may rescind this Agreement within 3 days of signing it by sending written notice by registered or certified mail to the Provider. The effective date of the rescission notice will be the date the rescission is postmarked. If not rescinded, this Agreement will govern all medical services received by the Patient from Provider after the date of signing.

- C. Termination. If the Agreement has not been rescinded, either party may still terminate it at any time, but termination will not take effect until the next anniversary of the signing of the Agreement. To terminate this Agreement, send written notice by registered or certified mail to the Provider. This Agreement applies to any Claim that arises while it is in effect, even if you file a Claim or request arbitration after the Agreement has been terminated.

#### **ARTICLE 8 Severability**

If any part of this Agreement is held to be invalid or unenforceable, the remaining provisions will remain in full force and will not be affected by the invalidity of any other provision.

#### **ARTICLE 9 Acknowledgment of Written Explanation of Arbitration**

I have received a written explanation of the terms of this Agreement. I have had the right to ask questions and have my questions answered. I understand that any Claim I might have must be resolved through the dispute resolution process in this Agreement instead of having them heard by a judge or jury. I understand the role of the arbitrators and the manner in which they are selected. I understand the responsibility for arbitration related costs. I understand that I can rescind this Agreement within 3 (three) days of signing it.

I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

#### **NOTICE**

**BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL**

By: \_\_\_\_\_  
Patient or Patient's Representative

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

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Date

By: \_\_\_\_\_  
Physician or Authorized Representative

**CASPER ORTHOPAEDIC ASSOCIATES, P.C.**

Appointment Doctor \_\_\_\_\_ Date \_\_\_\_\_

**PATIENT INFORMATION (CHILDS name if applicable):**

Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

\*SSN \_\_\_\_\_ Age \_\_\_\_\_ Male  Female

DOB \_\_\_\_\_ Marital Status \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Employer \_\_\_\_\_ Work Status \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Phone \_\_\_\_\_ Occupation \_\_\_\_\_

**RESPONSIBLE PARTY / PARENT PRESENT WITH CHILD**

Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

\*SSN \_\_\_\_\_ Age \_\_\_\_\_ Male  Female

DOB \_\_\_\_\_ Marital Status \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Employer \_\_\_\_\_ Work Status \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Phone \_\_\_\_\_ Occupation \_\_\_\_\_

**SPOUSE / OTHER RESPONSIBLE PARTY**

Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

\*SSN \_\_\_\_\_ Age \_\_\_\_\_ Male  Female

DOB \_\_\_\_\_ Marital Status \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Employer \_\_\_\_\_ Work Status \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Phone \_\_\_\_\_ Occupation \_\_\_\_\_

**INSURANCE 1**

Ins. Co. Name \_\_\_\_\_

Insured Policy Holder \_\_\_\_\_

Insured DOB \_\_\_\_\_ SSN \_\_\_\_\_

Policy ID # \_\_\_\_\_ Group ID # \_\_\_\_\_

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

Claims Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Phone # \_\_\_\_\_

Pre Certification Phone # \_\_\_\_\_

**INSURANCE 2**

Ins. Co. Name \_\_\_\_\_

Insured Policy Holder \_\_\_\_\_

Insured DOB \_\_\_\_\_ SSN \_\_\_\_\_

Policy ID # \_\_\_\_\_ Group ID # \_\_\_\_\_

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

Claims Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Phone # \_\_\_\_\_

Pre Certification Phone # \_\_\_\_\_

**CURRENT INJURY INFORMATION**

Type: Accident Work Auto Date \_\_\_\_\_

Place \_\_\_\_\_ Time \_\_\_\_\_

Body Part: \_\_\_\_\_ Right Left Bilateral

Description of Accident \_\_\_\_\_

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

**RELATIVE / FRIEND NOT LIVING IN HOME**

Last \_\_\_\_\_ First \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_

**\*Disclosure of this information is voluntary. However, failure to provide this information will result in no credit being extended and all services must be paid for at the time they are rendered.\***

I authorize treatment of the patient named above and agree to pay all fees and charges for such treatment. Charges shown by statements are agreed to be correct and reasonable, unless protested in writing within thirty days of the billing date. If in the event legal action should become necessary to collect an unpaid balance due for medical services rendered, I agree to pay reasonable attorney's fees or other such costs as the Court determines proper. I authorize Casper Orthopaedic Associates, P.C. to obtain credit/employment information required for collection purposes.

X-rays taken at Casper Orthopaedic Associates, P.C. will remain the property of Casper Orthopaedic Associates, P.C. Copies of x-rays can be provided for a small fee.

It may be necessary for additional tests to be ordered and performed outside of Casper Orthopaedics Associates, P.C. I authorize transfer of medical information, patient information and insurance information to the following outside sources: Wyoming Medical Center, Casper Surgical Center, Wyoming Surgical Center, Wyoming Imaging Center, Casper Medical Imaging, Diagnostic Lab, and Medical Testing Lab and/or other medical facilities if indicated. I have the right to amend, revoke and to obtain a written report annually of all disclosures of health information.

Casper Orthopaedics will routinely call the patient to remind them of an upcoming appointment. A message will be left on your voice mail or answering machine regarding the date and the time of that appointment and / or accounting issues.

It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims.

Signature of Responsible Party \_\_\_\_\_ Date \_\_\_\_\_

I have received the Patient Information Brochure \_\_\_\_\_ / \_\_\_\_\_  
Patient Signature Date

### PRIVACY NOTIFICATION

By signing below, you acknowledge that you have been informed of the Notice of Information Privacy Practices ("Notice") from Casper Orthopaedic Associates, P.C. You have the right to review our Notice prior to signing this acknowledgment. The terms of the Notice may change. If the terms do change, you may obtain a revised Notice by simply contacting Casper Orthopaedic, P.C. at (307) 265-7205 and request a revised Notice. We will also post any revised Notice at 4140 Centennial Hills Boulevard. You have the right to request that we restrict our uses or disclosures of your protected health information, which we are otherwise permitted to make for treatment, payment and healthcare operations, although we are not required to agree to those restrictions.

Acknowledgment \_\_\_\_\_ Date \_\_\_\_\_

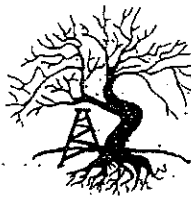
### INSURANCE OPTION

I hereby authorize and request payment to be made directly to Casper Orthopaedic Associates, P.C. for medical treatment provided to myself or any member of my family covered by my medical insurance program. If necessary, I authorize release of medical information relative to any claims submitted to my insurance company. I understand that any part of my bill not paid by my insurance company is my responsibility. Further, should my insurance company not honor this assignment of benefits, I will immediately forward any payment made directly to me by my insurance carrier. This authorization shall remain in effect for twelve (12) months from the date signed. I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do, it will not have any affect on any actions they took before they received the revocation.

Insurance 1 \_\_\_\_\_ Insurance 2 \_\_\_\_\_

Insured Policy Holder Name \_\_\_\_\_ Insured Policy Holder Name \_\_\_\_\_  
(Signature) (Signature)

Date \_\_\_\_\_ Date \_\_\_\_\_



**Casper  
Orthopaedics**

Sports, Spine, Bones, Joints & Trauma

4140 CENTENNIAL HILLS BLVD., SUITE A • CASPER, WYOMING 82609  
PHONE (307) 265-7205 • FAX (307) 235-6262  
1-888-317-2343

## ASSIGNMENT OF INSURANCE BENEFITS

If you would like us to process your insurance claims, please provide us with ALL the information requested below and sign beneath the statement.

NAME OF PATIENT \_\_\_\_\_

### POLICY HOLDER'S INFORMATION

NAME OF POLICY HOLDER \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

SOCIAL SECURITY# \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

ID# \_\_\_\_\_ GROUP POLICY NUMBER \_\_\_\_\_

POLICY HOLDER'S EMPLOYER \_\_\_\_\_

EMPLOYER'S ADDRESS \_\_\_\_\_

EMPLOYER'S TELEPHONE NUMBER \_\_\_\_\_

NAME OF INSURANCE COMPANY \_\_\_\_\_

ADDRESS WHERE CLAIMS ARE SUBMITTED \_\_\_\_\_

INSURANCE COMPANY'S TELEPHONE NUMBER - \_\_\_\_\_

We will file past claims for this condition/injury from the date you were initially seen for the said injury/condition, unless a specified date is indicated. \_\_\_\_\_

I hereby authorize and request payment to be made directly to Casper Orthopaedic Associates, P.C. for medical treatment provided to myself or any member of my family covered by my medical insurance program. If necessary, I authorize release of medical information relative to any claims submitted to my insurance company. I understand that any part of my bill not paid by my insurance company is my responsibility. Further, should my insurance company not honor this assignment of benefits, I will immediately forward any payment made directly to me by my insurance carrier. This authorization shall remain in effect for twelve (12) months from the date signed. I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do, it won't have any affect on any actions they took before they received the revocation. If in the event legal action should become necessary to collect an unpaid balance due for medical services rendered or supplies, I agree to pay reasonable attorney's fees or other such costs as the court determines proper.

SIGNATURE OF PRIMARY POLICY HOLDER \_\_\_\_\_ DATE \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Referring Physician:** \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_

**ALLERGIES:**

Allergy		Reaction
Latex	Yes	No
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**MEDICATIONS:**

Medication	Dose
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**PREVIOUS SURGERIES:**

Surgery	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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

**Reviewed RN Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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