

Patient Information Record
Please PRINT All Information

PATIENT ACCOUNT NO.

DATE

PATIENT INFORMATION

PATIENT'S NAME (LAST, FIRST, MI)				
STREET ADDRESS		CITY	STATE	ZIP
HOME PHONE	WORK PHONE	CELL or ALTERNATE PHONE		
EMAIL ADDRESS:				
SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	MARTIAL STATUS <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Legally Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Unknown <input type="checkbox"/> Widowed	AGE	DATE OF BIRTH	HAVE YOU EVER BEEN A PATIENT IN THIS OFFICE BEFORE <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, WHEN?
OCCUPATION		EMPLOYER		
WORK ADDRESS				
SPOUSES NAME (LAST, FIRST, MI)			SPOUSES DATE OF BIRTH	
STUDENT STATUS Full Time Part Time Not a Student	PRIMARY CARE PHYSICIAN	ADDRESS	PHONE	

PERSON RESPONSIBLE FOR PAYMENT IF OTHER THAN PATIENT

NAME		RELATIONSHIP
ADDRESS		
OCCUPATION	EMPLOYER	PHONE
ADDRESS	WORK PHONE	

POLICY HOLDER INFORMATION

PRIMARY INSURANCE INFORMATION		
INSURANCE COMPANY	NAME OF POLICY HOLDER	
GROUP #	CERTIFICATE/POLICY/ ID#	POLICY HOLDERS DATE OF BIRTH
MEDICARE #	MEDICAID #	
SECONDARY INSURANCE INFORMATION		
INSURANCE COMPANY	NAME OF POLICY HOLDER	
GROUP #	CERTIFICATE / POLICY / ID #	

Assignment of Benefits:

I hereby assign and authorize my insurance carrier including Medicare, other government sponsored insurances of which I may be covered and/ or all commercial payors to make payments on my behalf directly to Anne Arundel Dermatology. I also assign any Medigap benefits to be paid directly to my provider. I permit a copy of this authorization to be used in place of the original.

Signed _____

Date _____

***A fee may be incurred for No Show and/or cancellation without required notice. Initial _____ Date _____ ***

How did you hear about Anne Arundel Dermatology, P.A. and Affiliate Practices

Radio Insurance Website Magazine Google Search Social Media Family/Friend Physician Referral Other: _____

Patient Name: _____

Date of Birth: _____

General Consent/Agreement to Outpatient Services

This form applies to all Anne Arundel Dermatology practice sites. This form must be completed by all new patients, at least once a year for established patients, and any time there are changes in patient name, address, phone or other insurance information. Ask patients about changes at each visit.

CONSENT TO TREATMENT: I consent to receive medical and/or cosmetic health care services provided by Anne Arundel Dermatology (AADerm) entities. I understand that such services may include but are not limited to examination and treatment of skin disorders, performing cryosurgery, shave biopsies, punch biopsies or other minimally invasive testing on lesions, and sending specimens to a pathology or other lab for diagnosis. I authorize the examination, use, storage and disposal of all tissue, fluids, or specimens removed from my body. I acknowledge that no warranty or guarantee has been made to me as to result or cure. I understand that I could be tested for HIV, and have the right to opt out. I understand that my consent will be requested for HIV and other testing in case of an unintended exposure of a healthcare worker.

FINANCIAL AGREEMENT: I agree to furnish current, valid proof of insurance coverage as well as a copy of my driver's license or other state-issued photo ID at each office visit to confirm my identity and coverage. I will report any changes in insurance or other personal information promptly.

I agree that if I am a parent/ legally authorized representative/guarantor consenting to care and treatment of a minor child, I am responsible for payment and will receive billing statements. Parents are presumed to be legal representatives for their minor children unless legal documents proving otherwise are shared with the office. Please discuss any insurance or custody concerns with the office manager.

I understand that if I do not show up for a scheduled visit and do not notify the office, I will pay a NO SHOW fee of \$50.00. If I cancel my appointment in advance, or on the day I am scheduled, my appointment will be rescheduled without a fee. If I repeatedly cancel, a cancellation fee may be charged.

I understand that knowing about my insurance coverage is my responsibility and will contact the insurer for coverage questions. If my carrier requests information from me, I agree to comply promptly with such requests. AADerm is authorized to bill my health plan for the care I receive and I know that payments from my health plan will go directly to Anne Arundel Dermatology. If I should receive the payments, I understand that I will be responsible for paying AADerm. I understand that I must pay any co-payment or other part of the bill that my health plan says I must pay. I know that I may need to pay this before I am treated. In a situation of financial hardship, I agree to contact the billing department to make payment arrangements. I understand that final payment is due upon receipt of my billing statement. I know I can pay outstanding charges by cash or check, credit card, or Care Credit and that there is a \$25.00 service fee for returned checks. I understand that past due accounts may be referred to a collection agency. Additional fees may be incurred when accounts are sent to collection and I may be reported to credit reporting agencies. Office visits are at risk of being terminated when non-payment is a persistent, issue.

AADerm will not routinely waive co-payments or deductibles.

I understand that AADerm will hold me financially responsible in any one of the following situations:

- a. When I choose to have a service that my health plan covers but I do not obtain the required referral or authorization from my health plan.
- b. When I choose not to use my health plan and agree to pay for services myself. (Use Do Not Bill Insurance Form).
- c. When my health plan does not participate with AADerm or its providers for the services I want or need and I agree to pay for my care myself. I know that out of network services are charged Medicare allowable rates.
- d. When I receive services that are not covered under my health plan including cosmetic services.

If my health plan is subject to ERISA (the Employee Retirement Income Security Act under U.S. law), I agree to have AADerm act on my behalf to obtain my benefits when AADerm asks to do so. I also agree that AADerm can appeal for me if the health plan says it will not pay for my care. I understand that I must comply with the policies and procedures set by my employee benefit plan.

PATHOLOGY/LAB CHARGES: Pathology and lab charges are billed separately. If your provider elected to send your tissue to the AADerm Pathology Lab or a different pathology lab, you will receive a separate bill from the pathology provider for charges resulting from those services. There are two components to dermatopathology services – the technical component, or TC, which encompasses slide preparation and the professional component, or PC, which encompasses review of the prepared slides under a microscope and professional interpretation of the results. Your detailed bill will outline the components of the service and the specific provider of each service.

CONSENT TO PHOTOGRAPH: I understand photographs, videotapes, digital and/or other images may be made/ recorded for identification, treatment and payment purposes. I will specifically authorize in writing any other use or disclosure of my image or recording.

ELECTRONIC PRESCRIBING: I authorize SureScripts, an electronic prescribing network, to release my medication refill history to AADerm for the purpose of continued treatment.

MY PERSONAL BELONGINGS: I understand that I am responsible for my personal belongings and valuables.

RELEASE OF INFORMATION: I authorize AADerm practice site(s) to release healthcare information for purposes of treatment, payment, or healthcare operations. Healthcare information from or regarding prior encounter(s) at other AADerm practice locations may be made available to subsequent AADerm-affiliated sites to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.

If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, laboratory reports, operative reports, physician progress notes, nurse's notes, and consultations.

Federal and state laws may permit this medical practice to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

DISCLOSURES to FAMILY and FRIENDS: I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

COMMUNICATION CONSENT and TELEPHONE CONSUMER PROTECTION ACT: I agree that when I provide my landline or cell phone number(s) below, I am giving express consent for AADerm and its associates, assignees, successors, and agents, to contact me at these numbers, or at any number that is later acquired for me and to leave live or pre-recorded messages on voicemail or to text, regarding scheduling or scheduled appointments, my services, or my bill. For greater efficiency, calls or texts may be delivered by an auto-dialer. I realize that as a consequence of providing this consent I may receive future calls or text messages that deliver pre-recorded messages by or on behalf of AADerm. Charges from your carrier may apply. Providing a telephone or cell number is not a condition of receiving services.

You may be contacted via voicemail, text, or email to remind you of an appointment, to obtain feedback on your experience with our healthcare team, to provide newsletters and marketing promotions, and to provide general health information. I consent to receiving healthcare communications at the phone number, or e-mail address provided. This request to receive emails and text messages applies to future communications unless I request a change in writing.

Home Phone: _____ Cell Phone: _____

Authorized email address: _____

OR

(Initials) _____ I decline to receive communication via text.

(Initials) _____ I decline to receive communication via email.

Revocation

I hereby revoke my request for future communications via email and/or text.

I hereby revoke my request to receive any future appointment reminders, feedback, marketing and general health via text

I hereby revoke my request to receive any future appointment reminders, feedback, marketing, and general health via email.

NOTE: This revocation only applies to communications from this Practice.

Patient Name: _____

Patient/Patient Representative Signature: _____

Date: _____ Time: _____

NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received/reviewed AADerm's Notice of Privacy Practices. I understand that I may contact the Privacy Officer if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

I agree to the items as outlined in the Agreement.

Name (Print): _____ Signature: _____ Date: _____

Relationship to Patient (Self/Parent/Personal Representative): _____



Date: _____ DOB: _____ MRN: _____

Patient Name: _____

Referring Provider: _____

MEDICATION ALLERGIES: _____

Pharmacy Name: _____ Pharmacy Phone Number: _____

Pharmacy Address: _____

MEDICAL HISTORY AND INTAKE FORM

Past Medical History: (Please circle all that apply)

Anxiety	COPD (Chronic Obstructive Pulmonary Disease)	Hypercholesterolemia (High Cholesterol)
Arthritis	Coronary Artery Disease	Hyperthyroid (Overactive Thyroid)
Asthma	Depression	Hypothyroid (Underactive Thyroid)
Atrial Fibrillation (Irregular Heartbeat)	Diabetes	Radiation Treatment
Bone Marrow Transplantation	End Stage Renal (Kidney) Disease	Seizures
BPH (Enlarged Prostate)	GERD (Acid Reflux)	Stroke
Cancer: Type(s) _____	Hearing Loss	None
_____	Hepatitis/Liver Disease	
_____	Hypertension(High Blood Pressure)	OTHER: _____
	HIV/AIDS	_____

Past Surgical History: (Please circle all that apply)

Appendix (Appendectomy)	Joint Replacement: Knee (Both)	Pancreas: Pancreatectomy
Bladder (Cystectomy)	Joint Replacement: Knee (Left)	Prostate(Prostatectomy): Prostate Cancer
Breast: Lumpectomy (Both Breasts)	Joint Replacement: Knee (Right)	Prostate(Prostatectomy): Prostate Biopsy
Breast: Lumpectomy (Left Breast)	Joint Replacement: Hip (Both)	Prostate:TURP(Transurethral Resection of the Prostate)
Breast: Lumpectomy (Right Breast)	Joint Replacement: Hip(Left)	Rectum: APR(Abdominoperineal Resection)
Breast: Mastectomy (Both Breasts)	Joint Replacement: Hip(Right)	Rectum: Lower Anterior Resection
Breast: Mastectomy (Left Breast)	Kidney: Kidney Biopsy	Skin: Biopsy
Breast: Mastectomy (Right Breast)	Kidney: Nephrectomy	Skin: Basal Cell Carcinoma
Breast: Breast Biopsy	Kidney: Kidney Stone Removal	Skin: Squamous Cell Carcinoma
Colon (Colectomy): Colon Cancer Resection	Kidney: Kidney Transplant	Skin: Melanoma
Colon (Colectomy): Diverticulitis	Liver: Shunt	Spleen (Splenectomy)
Colon (Colectomy): Inflammatory Bowel Disease	Liver: Liver Transplant	Testicles(Orchiectomy)
Colon: Colostomy	Liver: Hepatectomy	Uterus(Hysterectomy): Fibroids
Gall Bladder(Cholecystectomy): Removed	Ovaries(Oophorectomy): Endometriosis	Uterus(Hysterectomy): Uterine Cancer
Heart: Coronary Artery Bypass Surgery	Ovaries(Oophorectomy): Ovarian Cyst	Uterus(Hysterectomy): Cervical Cancer
Heart: PTCA(Coronary Angioplasty)	Ovaries(Oophorectomy): Ovarian Cancer	
Heart: Mechanical Valve Replacement	Ovaries: Tubal Ligation	
Heart: Biological Valve Replacement		
Heart: Heart Transplant		

OTHER: _____

*****Please fill in reverse side of sheet also*****

Skin Disease History: (please circle all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratosis (pre-cancerous lesions)	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/ Allergies	Squamous Cell Cancer
Blistering Sun Burns	Melanoma	Other: _____

Do you wear sunscreen? Yes No If yes, what SPF _____

Do you tan in a tanning salon? Yes No

Do you have a family history of **Melanoma**? If yes, which relative(s)? _____

Social History:

Smoking Status: (Please circle one)

Current every day smoker
 Current some day smoker: Tobacco
 Current some day smoker: Cigarettes
 Former Smoker

Never Smoker
 Smoker: Current status unknown
 Unknown if ever smoked
 Heavy tobacco smoker
 Light tobacco smoker

Alcohol Status: (Please circle one)

None
 Less than 1 drink per day
 1-2 drinks per day
 3 or more drinks per day

Occupation: _____

Hobbies: _____

Family History:(please check all that apply)

Acne	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Other	<input type="checkbox"/> None
Arthritis	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Other	<input type="checkbox"/> None
Asthma	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Other	<input type="checkbox"/> None
Diabetes	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Other	<input type="checkbox"/> None
Eczema	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Other	<input type="checkbox"/> None
Hay Fever/Allergies	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Other	<input type="checkbox"/> None
Lupus	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Other	<input type="checkbox"/> None
Psoriasis	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Other	<input type="checkbox"/> None
Non-Melanoma Skin Cancers	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/> Other	<input type="checkbox"/> None

Review of Systems: Do you have or are you currently experiencing any of the following? (Please circle yes or no)

Changing mole	Yes	No	Muscle weakness	Yes	No
Rash	Yes	No	Neck Stiffness	Yes	No
Fever or chills	Yes	No	Headaches	Yes	No
Depression	Yes	No	Seizures	Yes	No
Anxiety	Yes	No	Cough	Yes	No
Problems with healing	Yes	No	Shortness of breath	Yes	No
Problems with bleeding	Yes	No	Wheezing	Yes	No
Problems with scarring (hypertrophic or keloid)	Yes	No	Pacemaker	Yes	No
Immunosuppression	Yes	No	Defibrillator	Yes	No
Hay fever	Yes	No	Blood thinners	Yes	No
Chest pain	Yes	No	GI upset with antibiotics	Yes	No
Night sweats	Yes	No	Allergy to adhesive	Yes	No
Unintentional weight loss	Yes	No	Allergy to lidocaine	Yes	No
Thyroid problems	Yes	No	Allergy to topical antibiotic ointments	Yes	No
Sore throat	Yes	No	Artificial heart valve	Yes	No
Blurry vision	Yes	No	Artificial joint within the past 2 years	Yes	No
Abdominal pain	Yes	No	MRSA	Yes	No
Bloody stool	Yes	No	Premedication prior to procedures	Yes	No
Bloody urine	Yes	No	Rapid heartbeat with epinephrine	Yes	No
Joint aches	Yes	No	Pregnancy or planning a pregnancy	Yes	No
			Nursing	Yes	No

Immunizations: Have you had the following immunizations?

Vaccine:	Date of Vaccination (can be approximate if unsure):
Influenza (Flu)	_____
Pneumonia	_____
Varicella (Shingles)	_____

To Parents and Guardians of Minor Children:

The providers and staff of Anne Arundel Dermatology, P.C. (“AAD”) place great emphasis on the health and well-being of each and every patient that comes to our offices. We appreciate that you have entrusted us to provide dermatology services to your minor child and we look forward to working with you to ensure that your child receives the best health care possible.

Please see the Consent to Treat a Minor form that, once completed by a parent or legal guardian, will be placed in your child’s medical record for use as necessary. This form will allow us to provide routine and emergency medical treatment for your minor child as necessary. This consent form will remain in effect until revoked in writing. You may request this form from any member of our office staff.

As a general rule, we require the consent of a parent or legal guardian in order to provide health care services to a minor child (someone under the age of 18). You will be asked to sign the authorization for treatment on or before the first visit, and to come to the office for as many visits as possible. The authorization allows you to approve: a) a course of therapy for your child with your participation and consent; b) that other responsible adults that you name may bring your child to the office; c) that we treat your adolescent child when s/he comes to the office unaccompanied by a responsible adult; and, d) that we can help in a health emergency. If your minor child presents to the office unaccompanied, we will check that you have signed the authorization to treat your adolescent child in your absence, and will reschedule if we do not have your written approval. If the minor presents in the company of an adult other than a parent or legal guardian, we will check that they are the persons named in the authorization; or that you have otherwise authorized in writing your consent.

Adults, other than the parent or legal guardian who accompany a minor child to an appointment and are authorized by the Consent to Treat a Minor on record, will be asked to present a photo ID upon checking the patient in for the appointment. If consent documentation or photo identification is missing, the appointment will be rescheduled.

By law, minors have the right to consent to health care under specific circumstances. For the purposes of dermatology care, a minor may consent to care if s/he is married, or is self-supporting regardless of income. A minor who is also a parent may consent to treatment for his or her child, even if the parent is under age 18.

It is the philosophy of this medical practice to encourage minor patients to include a parent, guardian or other trusted adult in all aspects of their health care. If you have questions regarding any of this information, please contact your child’s treating physician.

Consent to Treat a Minor

Patient name: _____ Date of birth: _____
 Patient name: _____ Date of birth: _____
 Patient name: _____ Date of birth: _____

I, the undersigned, parent(s) or legal guardian of the above named patient, a minor, do hereby authorize the physicians, physician assistants, and nurse practitioners, at any Anne Arundel Dermatology, P.C. ("AAD") practice site to provide healthcare services as outlined in the General Agreement to Outpatient Services, including assessment, planning, diagnosis and treatment approved by a supervising physician who is licensed to practice in the state where the minor's healthcare service is being rendered.

In an emergency, it is understood that authorization is granted to the physicians, physician assistants, and nurse practitioners at AAD to provide emergency care, treatment, and/ or hospital referral which is deemed necessary in the exercise of his or her best judgment.

Consent to Treat a Minor Child accompanied by an adult other than the child's parent or legal guardian.

I, the parent or legal guardian of the patient named above, do hereby authorize the physicians at AAD to perform medical treatment as per the statements above when accompanied by either of the following named adult persons over the age of 18:

Adult's name: _____ Relationship to the child: _____
 (Print Name) (Grandparent, Aunt, Uncle, Sister, Brother, Family Friend)

Adult's name: _____ Relationship to the child: _____
 (Print Name) (Grandparent, Aunt, Uncle, Sister, Brother, Family Friend)

I authorize my adolescent child to be treated at the office visit(s) if I am unable to attend.

This authorization is valid:

- For any and all medical treatment.
- For today only.
- For this specific problem(s) or a specific date range. Please specify:

This consent will be valid until revoked in writing by me from the date signed unless otherwise specified in writing.

Parent or legal guardian: (Print Name) _____ Date: ____ / ____ / ____
 Parent or legal guardian signature: _____
 Witness: (Print Name) _____ Signature: _____

Medications:

Please list all current medications including prescriptions, over-the-counter medications, vitamins, minerals and supplements. **If not currently on medications, write NONE or N/A.**

Please check box and do not fill out medication list if you have been seen in the last 6 months **AND** you gave us your medication list at that time **AND** your medication list has not changed.

Name of Prescribed Medication	Dose	Route	Frequency
Example: Lipitor 20 mg	1 tablet	Orally	Once a day

Over the Counter Medication	Dose	Route	Frequency
Example: Fish Oil 1000 mg	1 tablet	Orally	Once a day

Patient Name: _____

DOB: _____

MIPS Questionnaire

Today's Date: _____

Patient Questionnaire

1. Are you a tobacco **smoker**? **Current / Former / Never**
(Please circle answer)

2. Have you received an Influenza Vaccine during flu season (August 2020-March 2021 or August 2021-March 2022)?

Yes / No

If NO, select reason why: Refused / Allergy

For Patients 65 years and older

3. Have you ever had a Pneumonia Vaccine (Pneumovax 23 and/or Prevnar 13)?
Yes / No *(Please circle answer)*

4. Do you have a health care proxy in the event you are unable to make your own medical decisions? **Yes / No** *(Please circle answer)*

5. Do you have a living will? **Yes / No** *(Please circle answer)*

6. Which statement(s) best reflects your wishes on advanced care recommendations? *(Please check all that apply)*

- Do Not Intubate:** I do not wish to have a breathing tube, even if it is necessary to save my life.
- Do Not Resuscitate:** If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it's necessary to save my life.
- Full Cardiopulmonary Resuscitation:** I want full cardiopulmonary resuscitation efforts to be made.

Patient Name: _____ DOB: _____

Primary Care Physician: _____