

<b>Today's Date</b> (month/day/year)		<b>Preferred Name</b>	
<b>First Name</b>		<b>Last Name</b>	
<b>Social Security Number</b>		<b>Date of Birth</b> (month/day/year)	
<b>Home Address</b>			
<b>City</b>		<b>State</b>	<b>Zip Code</b>
<b>Phone Number</b>		<b>Alternate Phone Number</b>	
<b>Email Address</b>			

Patient Demographics	
<b>Legal Sex</b> <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Nonbinary <input type="checkbox"/> Unknown <input type="checkbox"/> X	
<b>Gender Identity</b> <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Non-Binary / Genderqueer <input type="checkbox"/> Transgender Male / Trans Man / FTM <input type="checkbox"/> Transgender Female / Trans Woman / MTF <input type="checkbox"/> Questioning <input type="checkbox"/> Two Spirit <input type="checkbox"/> Other <input type="checkbox"/> Choose Not To Disclose	<b>Sexual Orientation</b> <input type="checkbox"/> Straight or Heterosexual <input type="checkbox"/> Pansexual <input type="checkbox"/> Lesbian <input type="checkbox"/> Queer <input type="checkbox"/> Gay <input type="checkbox"/> Something Else <input type="checkbox"/> Bisexual <input type="checkbox"/> Don't Know <input type="checkbox"/> Asexual <input type="checkbox"/> Choose Not to Disclose / Decline <input type="checkbox"/> Omnisexual
<b>Patient's Sex Assigned at Birth</b> <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Intersex <input type="checkbox"/> Unknown <input type="checkbox"/> Not Recorded on Birth Certificate <input type="checkbox"/> Choose Not To Disclose	
<b>Marital Status</b> <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	
<b>What is your ethnicity?</b> <input type="checkbox"/> Non-Hispanic or Latino/a <input type="checkbox"/> Mexican, Mexican American, or Chicano/a <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Don't Know <input type="checkbox"/> Another Hispanic, Latino/a or Spanish Origin <input type="checkbox"/> Multiple Hispanic, Latino/a or Spanish Origins <input type="checkbox"/> Choose Not To Disclose	
<b>What is your race or biological family background?</b> <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Alaska Native <input type="checkbox"/> American Indian <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Choose Not To Disclose <input type="checkbox"/> Don't Know	

Emergency Contact	
<b>Name</b>	
<b>Phone Number</b>	<b>Relationship to Patient</b>
Employment	
<b>Employment Status</b> <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Unemployed	
Language	
<b>Do you need an interpreter?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Do you speak English?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No My preferred language is _____
<b>English Fluency</b> <input type="checkbox"/> Excellent <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Not Good <input type="checkbox"/> Not at All	
<b>Preferred Written Language</b>	<b>Preferred Language Spoken</b>

Additional Demographics	
<b>Are you experiencing homelessness?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No (Not Homeless) <input type="checkbox"/> Currently Not Homeless (was in the last 12 months)	
<b>If Yes, please choose one (1) below</b> <input type="checkbox"/> Living in Shelter (Homeless Shelter) <input type="checkbox"/> Transitional Housing <input type="checkbox"/> Living with Others (Doubling Up) <input type="checkbox"/> Street, Camp, Bridge <input type="checkbox"/> Homeless Unknown Shelter <input type="checkbox"/> Permanent Supportive Housing <input type="checkbox"/> Single Occupancy Hotel (Other) <input type="checkbox"/> At Risk for Homelessness <input type="checkbox"/> At Risk for Homelessness (Child) <input type="checkbox"/> At Risk for Homelessness (Veteran)	
<b>Are you a migrant / seasonal worker?</b> <input type="checkbox"/> Migrant <input type="checkbox"/> Seasonal <input type="checkbox"/> Neither	
<b>Veteran / Military Status</b> <input type="checkbox"/> Yes <input type="checkbox"/> No, I am not a veteran (or served in the military)	
<b>Country of Origin (optional)</b> _____	

**Would you like assistance during your appointment?**

- Yes, support for Low Vision or Blindness.
- Yes, Hard of hearing.
- Yes, Mobility Assistance (please describe) \_\_\_\_\_
- Yes, other (please describe) \_\_\_\_\_

**What pronouns do you use?**

- She / Her / Hers     He / Him / His     They / Them / Theirs     Ze / Hir / Hirs     Ey / Em / Eirs     Xe / Xem / Xyrs
- Ve / Vir / Virs     Other     Patient's Name     Unknown     Decline to Answer

**Communication Preferences (Circle all that apply)**

How would you like to be contacted for Appointments?	Phone	Text	Email	Mail
Billing Issues	Phone	Text	Email	Mail
Healthcare Questions / Results	Phone	Text	Email	Mail
Messages from Your Provider	Phone	Text	Email	Mail
Other Communication	Phone	Text	Email	Mail

**Guarantor Information**

- Self
- For children - name of parent or legal guardian \_\_\_\_\_ Day of Birth (month/day/year) \_\_\_\_\_
- Address (if different from patient's) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ ZIP Code \_\_\_\_\_
- Relationship to Patient \_\_\_\_\_

**Total number of people in your household (you and your dependents)** \_\_\_\_\_

- What is your household income before taxes \$ \_\_\_\_\_  Hourly  Weekly  Monthly  Annual
- Choose Not to Disclose

*Note:* I understand that if I choose not to disclose my household income and number of people in my household, I decline participation in Elica's financial assistance program (Sliding Fee). If my circumstances change, or if I change my mind, I know that I can ask a staff member for an application.

**Insurance**

Medicare Member ID Number \_\_\_\_\_ Effective Date \_\_\_\_\_

Medicaid Member ID Number \_\_\_\_\_ Effective Date \_\_\_\_\_

1. Give receptionist your insurance card and ID to scan in your chart
2. Turn in sliding fee application and proof of income for sliding scale (if self-pay)

**BY SIGNING BELOW, I CONFIRM THAT THE INFORMATION PROVIDED ON THE PATIENT REGISTRATION FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.**

\_\_\_\_\_  
Print Name of Patient

\_\_\_\_\_  
Relationship to Patient of Individual Signing Form  
(for example: patient, parent, guardian)

\_\_\_\_\_  
Patient / Guardian Signature

\_\_\_\_\_  
Date

## Consents & Acknowledgements

**Treatment:** I agree to receive treatment from Elica's providers and staff. I know that a medical record will be created about me. I can get a copy of my record by signing a Medical Records Authorization Form provided by the clinic.

**Telehealth:** I agree to receive care via telephone, telehealth, or the patient portal when medically necessary and clinically appropriate for exchanging medical information with my providers. Elica's providers can only legally treat patients located in California. Telehealth services cannot be provided to anyone currently outside of California for any reason.

**Students / Residents:** I understand that Elica is involved with the education of healthcare students. This means that students or residents may be present during visits for myself, my child, or the individual for whom I am a guardian. I understand that, under supervision of licensed healthcare providers, students or residents may assist with caring for myself, my child, or the individual for whom I am a guardian. I am aware that I can decline their participation in care at any time, and that this will not affect access to care.

**Assignment of Benefits:** I hereby assign all rights and benefits under my insurance policy to Elica allowing them to directly submit claims and receive payment from my insurance company on my behalf. I understand I am responsible for paying any charges my insurance doesn't cover, including the balance after discounts.

**Photographs:** I agree that Elica may take a photograph of myself, my child, or the individual for whom I am a guardian, for identification purposes in the health record. If I decline to have this photograph taken, I understand my legal photo ID may be used instead.

**Patient Pharmacy Free Choice:** I understand that I have the freedom to choose my pharmacy. Prescriptions will be sent to my pharmacy of choice. If eligible, I may be referred to a specific pharmacy for free or discounted medications. If I choose a different pharmacy, I may have to pay the full price.

**Notice of Privacy Practices:** I agree I was informed or have received a copy of Elica's Notice of Privacy Practices. I may access a copy of this at any time on Elica's website ([www.elicahealth.org](http://www.elicahealth.org)).

**Health Information Exchange:** Elica is part of an organized health care arrangement including participants in OCHIN. A current list of OCHIN participants is available at [www.ochin.org](http://www.ochin.org). As a business associate of Elica, OCHIN also engages in quality assessment and improvement activities on behalf of its participants. For example, OCHIN coordinates clinical review activities on behalf of participating organizations to establish best practice standards and access clinical benefits that may be derived from the use of electronic health record systems. OCHIN also helps participants work collaboratively to improve the management of internal and external patient referrals. I understand that health information may be shared by Elica with other OCHIN participants, when necessary for health care operation purposes of the organization is health care arrangement.

**BY SIGNING BELOW, I CONFIRM I HAVE READ THE CONSENT SECTION, AND UNDERSTAND AND ACCEPT ITS TERMS.**

\_\_\_\_\_  
Print Name of Patient

\_\_\_\_\_  
Relationship to Patient of Individual Signing Form  
(for example: patient, parent, guardian)

\_\_\_\_\_  
Patient / Guardian Signature

\_\_\_\_\_  
Date

# PROTECTED HEALTH INFORMATION AUTHORIZATION FORM - HIPAA

Elica Health Centers is committed to protecting your health information. This **HIPAA disclosure/non-disclosure form** allows you to add, update, or change how your protected health information is shared. This form helps us understand any new instructions you have about what details, if any, you would like us to share with the people in your life. Elica providers will only communicate with patients regarding their treatment or care in person, telephonically, or via the patient portal.

Patient Information			
<b>Last Name:</b>	<b>First Name:</b>	<b>Middle Initial:</b>	<b>Date of Birth:</b>
Message Preferences: Tell us the type of messages you prefer and what we can share. (Messaging and data rates may apply.)			
	<b>Phone</b>	<b>Text</b>	<b>Email/Portal</b>
<b>All of the below</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Health Notifications (such as lab or test results)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Appointment Reminders</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Announcements (such as new programs or community information)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Billing Notifications</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Who: Tell us who you would like us to share, or release, information with. Each box is for a different person.			
Person #1		Person #2	
<b>First and Last Name:</b>		<b>First and Last Name:</b>	
<b>Relationship:</b> <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> Wife <input type="checkbox"/> Husband <input type="checkbox"/> Partner <input type="checkbox"/> Guardian  <input type="checkbox"/> Other _____		<b>Relationship:</b> <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> Wife <input type="checkbox"/> Husband <input type="checkbox"/> Partner <input type="checkbox"/> Guardian  <input type="checkbox"/> Other _____	
<input type="checkbox"/> We can tell this person any and all of your medical information. <b style="text-align: center;">OR</b> <input type="checkbox"/> We can give this person today's chart notes at the time of the visit. <input type="checkbox"/> We can give this person all of your test results.		<input type="checkbox"/> We can tell this person any and all of your medical information. <b style="text-align: center;">OR</b> <input type="checkbox"/> We can give this person today's chart notes at the time of the visit. <input type="checkbox"/> We can give this person all of your test results.	
Person #3		Person #4	
<b>First and Last Name:</b>		<b>First and Last Name:</b>	
<b>Relationship:</b> <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> Wife <input type="checkbox"/> Husband <input type="checkbox"/> Partner <input type="checkbox"/> Guardian  <input type="checkbox"/> Other _____		<b>Relationship:</b> <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> Wife <input type="checkbox"/> Husband <input type="checkbox"/> Partner <input type="checkbox"/> Guardian  <input type="checkbox"/> Other _____	
<input type="checkbox"/> We can tell this person any and all of your medical information. <b style="text-align: center;">OR</b> <input type="checkbox"/> We can give this person today's chart notes at the time of the visit. <input type="checkbox"/> We can give this person all of your test results.		<input type="checkbox"/> We can tell this person any and all of your medical information. <b style="text-align: center;">OR</b> <input type="checkbox"/> We can give this person today's chart notes at the time of the visit. <input type="checkbox"/> We can give this person all of your test results.	
<input type="checkbox"/> <b>I do not want ANYTHING told or shared with ANYONE.</b>			
<p>By signing this <b>HIPAA disclosure/non-disclosure form</b>, I authorize Elica Health Centers to update and share my health information according to the changes I have indicated above. This authorization supersedes any previous authorizations I have provided to share my protected health information, and applies only to the information and individuals listed on this form.</p> <p>This authorization to share your private health information will expire <b>1 year from the date of signing this HIPAA disclosure/non-disclosure form</b> or upon (describe terminating event) _____.</p>			
_____ and Last Name of Patient		_____ Relationship to Patient (e.g., self, parent, guardian) <span style="float: right;">Print First</span>	
_____ Guardian Signature		_____ Date <span style="float: right;">Patient /</span>	
Office Use Only			
<b>Effective Date:</b>		<b>Updated By:</b>	



# PEDIATRIC HEALTH HISTORY AGES 0-12

<b>Patient Name</b>	<b>MRN:</b>	<b>Today's Date</b> (month/day/year)
<b>Date of Birth</b> (month/day/year)		

ALLERGIES TO ANY MEDICATIONS, FOOD OR OTHER SUBSTANCES?		
Allergic to:	Reaction:	Severity of Reaction:
	<input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Hives <input type="checkbox"/> Rash <input type="checkbox"/> Swelling <input type="checkbox"/> Nausea/ vomiting <input type="checkbox"/> Other: _____	<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High
	<input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Hives <input type="checkbox"/> Rash <input type="checkbox"/> Swelling <input type="checkbox"/> Nausea/ vomiting <input type="checkbox"/> Other: _____	<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High
	<input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Hives <input type="checkbox"/> Rash <input type="checkbox"/> Swelling <input type="checkbox"/> Nausea/ vomiting <input type="checkbox"/> Other: _____	<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High

MEDICAL HISTORY (Check all diseases and medical conditions that apply)					
<input type="checkbox"/> No Past Medical History					
<input type="checkbox"/> Abuse as Adult (victim)	<input type="checkbox"/> Asthma	<input type="checkbox"/> Depression	<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Sickle cell anemia
<input type="checkbox"/> Abuse as a child (victim)	<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Diabetes mellitus	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Stomach ulcers
<input type="checkbox"/> Allergies	<input type="checkbox"/> Cancer	<input type="checkbox"/> Emphysema/COPD	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Myocardial infarction	<input type="checkbox"/> Stroke
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cataracts	<input type="checkbox"/> GERD	<input type="checkbox"/> Hyperlipidemia	<input type="checkbox"/> Nerve/Muscle disease	<input type="checkbox"/> Substance abuse
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Clotting disorder	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> TB disease
<input type="checkbox"/> Arthritis/Join disorder	<input type="checkbox"/> COPD	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Seizures	<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Other, please explain:					

SURGICAL HISTORY		
<input type="checkbox"/> No Past Surgical History		
<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Cosmetic surgery	<input type="checkbox"/> Small intestine surgery
<input type="checkbox"/> Brain surgery	<input type="checkbox"/> Eye surgery	<input type="checkbox"/> Spine surgery
<input type="checkbox"/> Breast surgery	<input type="checkbox"/> Fracture surgery	<input type="checkbox"/> Third Molar Extraction

<input type="checkbox"/> CABG	<input type="checkbox"/> Hernia repair	<input type="checkbox"/> Tonsillectomy
<input type="checkbox"/> Cholecystectomy	<input type="checkbox"/> Joint replacement	<input type="checkbox"/> Valve replacement
<input type="checkbox"/> Colon surgery	<input type="checkbox"/> Prostate surgery	<input type="checkbox"/> Vasectomy
<input type="checkbox"/> Other, please explain:		

**FAMILY HISTORY (Check all diseases and conditions that apply)**

		No Known Problems	Alcohol/Drug Use	Allergies	Alzheimer's Disease	Anemia	Autoimmune Disease	Breast Cancer	Colon Cancer	Cancer	Depression	Diabetes	Heart Attack	High Cholesterol	Hypertension	Kidney Disease	Liver Disease	Lung Disease	Stroke	Sudden Death	Suicide	Thyroid Disease	Vision Problems	Other
Relationship	Name																							
Mother																								
Father																								
Sister																								
Brother																								
Daughter																								
Son																								
Maternal Aunt																								
Maternal Uncle																								
Paternal Aunt																								
Paternal Uncle																								
Maternal Grandmother																								
Maternal Grandfather																								
Paternal Grandmother																								
Paternal Grandfather																								
Other																								

**LIST ANY OTHER FAMILY MEDICAL HISTORY BELOW:**

Disease or medical problem:	Family member:

## Complete for children ages 8-12: SCARED, BRIEF (Child answers)

I get really frightened for no reason at all:	<input type="checkbox"/> Not true or Hardly ever true	<input type="checkbox"/> Somewhat True or Sometimes True	<input type="checkbox"/> Very True or Often True
I am afraid to be alone in the house:	<input type="checkbox"/> Not true or Hardly ever true	<input type="checkbox"/> Somewhat True or Sometimes True	<input type="checkbox"/> Very True or Often True
People tell me that I worry too much:	<input type="checkbox"/> Not true or Hardly ever true	<input type="checkbox"/> Somewhat True or Sometimes True	<input type="checkbox"/> Very True or Often True
I am scared to go to school:	<input type="checkbox"/> Not true or Hardly ever true	<input type="checkbox"/> Somewhat True or Sometimes True	<input type="checkbox"/> Very True or Often True
I am shy:	<input type="checkbox"/> Not true or Hardly ever true	<input type="checkbox"/> Somewhat True or Sometimes True	<input type="checkbox"/> Very True or Often True

## TB RISK ASSESSMENT

Recent close or prolonged contact with someone with infectious TB disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Born in or recent traveler to high prevalence area	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chest radiographs with fibrotic changes suggesting inactive or past TB	<input type="checkbox"/> Yes	<input type="checkbox"/> No
HIV infection	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Organ transplant recipient	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Immunosuppression secondary to use of prednisone (equivalent of > or = to 15mg/day for >or = 1 month) or other immunosuppressive medication such as TNF - $\alpha$ antagonist	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Injection drug user	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Resident or employee of high-risk congregate setting (e.g., prison, long-term care facility, hospital, homeless shelter)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Medical condition associated with risk of progressing to TB disease if infected (e.g. diabetes mellitus, silicosis, cancer of head or neck, Hodgkin's Disease, leukemia, end-stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight (10% or more below ideal for given population))	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Signs/Symptoms of TB**  Persistent Cough  Persistent fever  Unexplained weight loss  Loss of appetite  Persistent sweats  
 Chronic fatigue  Chills  Coughing up blood  Shortness of breath  Chest pain  None

## SOCIAL HISTORY (PRAPARE): For Parent or Caregiver

How hard is it for you to pay for the very basics like food, housing, heating, medical care, and medications?  
 Not hard at all  Somewhat hard  Very hard  Decline

What is your living situation today?  
 I have a steady place to live  
 I have a place to live today, but I am worried about losing it in the future  
 I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the streets, on the beach, in the car.)  
 Decline

In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?  
 Yes, it has kept me from medical appointments or getting medications  
 Yes, it has kept me from non-medical meetings, appointments, work, or getting things that I need  
 No  
 Declined



## ALLERGIES AND REACTIONS

Are you allergic to Latex? If yes, please explain the reaction.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you allergic to local anesthetic? If yes, please explain the reaction.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you allergic to Nitrous oxide? If yes, please explain the reaction.	<input type="checkbox"/> Yes	<input type="checkbox"/> No

\_\_\_\_\_  
**Patient / Legal Guardian Name**

\_\_\_\_\_  
**Relationship to patient of Individual Signing Form**  
(example: patient, parent, guardian)

\_\_\_\_\_  
**Patient / Legal Guardian Signature**

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

