LAFAYETTE ARTHRITIS AND ENDOCRINE CLINIC

4212 West Congress Street, Suite 2300A

Lafayette, LA 70506

PHONE (337) 237-7801

FAX (337) 233-2965

**TODD BAQUET, M.D.**

ENDOCRINOLOGY—**Suite 2300B** **when you arrive for your appt**

Dear Patient:

Welcome to Lafayette Arthritis and Endocrine Clinic. We are pleased that you have chosen us as your health care specialist, and look forward to seeing you at

\_\_\_\_\_\_\_\_\_\_\_\_\_ ON \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Time Day Date

The enclosed forms are necessary to open your medical record. These include the **Patient Registration Form, Authorization to Release Information, Information for Your Physician and Notice of Privacy Practices** forms. Please complete all forms, **PRIOR** to your visit, sign and date where indicated, and mail back to office at least one week prior to appointment so we may input data into our computer system. By doing so, your wait time, and the wait of those who are appointed after you, should be lessened.

**Also, bring all of your current medications and insurance card(s) with you to our office for EVERY appointment, as well as all current imaging and lab work deemed pertinent by the referring physician. If you are diabetic, bring a log of your blood sugars from 1-2 weeks prior to visit.** Bringing these items will help keep the cost of your visit down and may prevent having to repeat labs and imaging.

**Please note:** Your initial appointment will be with ***Dr. Todd Baquet.*** You will be seen by either Dr. Todd Baquet or our Nurse Practitioner at subsequent visits.

Our office requires a 24-hour cancellation notice. If you cannot make your scheduled appointment or need to reschedule, contact our office 24-hours prior. If we do not receive notice: **YOU** (not your insurance) will be billed for a missed appointment. Missed new patient appointments will be charged $50.00 and revisits $25.00. If an emergency occurs, please contact our office.

If you have any questions or need assistance with any of the questions on the forms, we will be glad to help you when you come or call us at 337-237-7801.

Again, welcome to our practice. We look forward to meeting you at your first appointment.

Sincerely,

Lafayette Arthritis and Endocrine Clinic

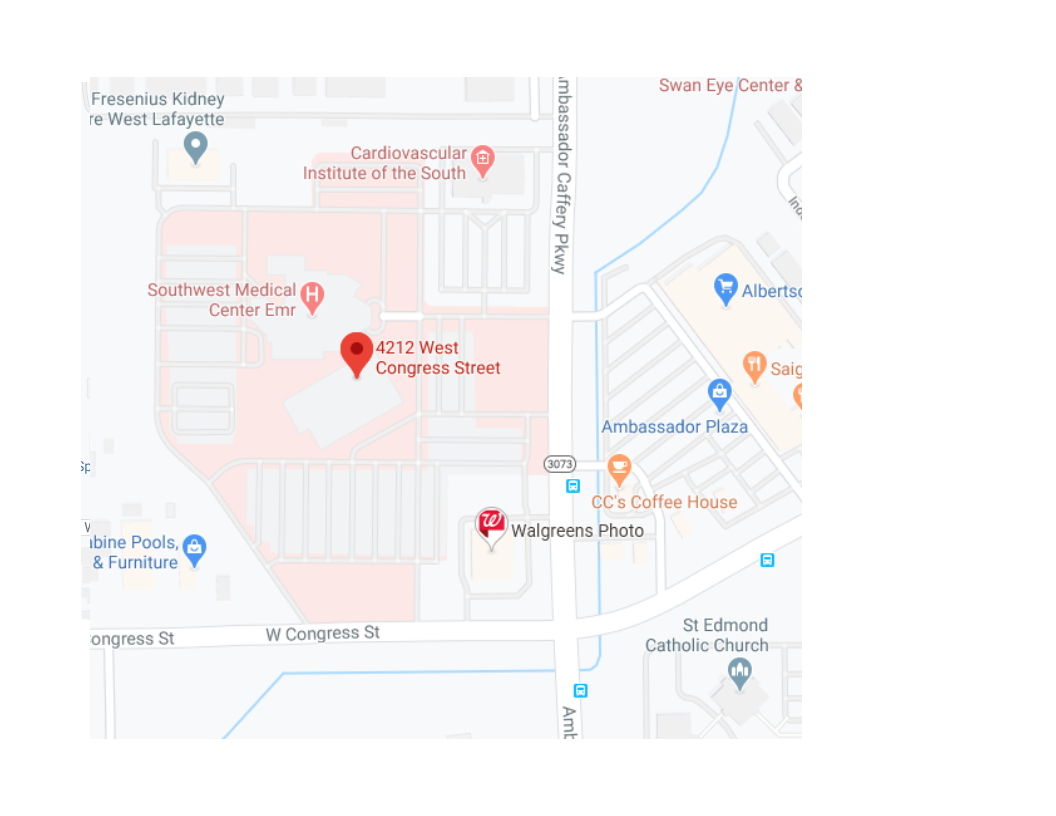
**DIRECTIONS**

**THIS IS FOR YOU TO KEEP—DO NOT MAIL BACK TO US**

LAFAYETTE ARTHRITIS AND ENDOCRINE CLINIC has moved!

Our new address is 4212 West Congress Street, Suite 2300A. Lafayette, LA 70506. **(mailing)**

Suite 2300B--**when you arrive for your appt**



Information for your physician: **Dr. Todd Baquet** Date\_\_\_/\_\_\_/\_\_\_

Please answer the following questions. It will help your physician to know about your health and family medical history.

Patients Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_ Zip\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_

Place of Employment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: Male\_\_\_ Female\_\_\_ Race \_\_\_\_\_Ethnicity\_\_\_\_\_\_ Name of responsible party (if other than patient): \_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_

Living Age or age of death Present Health or cause of death

Father…..Yes \_\_\_\_ No \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother… Yes \_\_\_\_ No \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse….Yes \_\_\_\_ No\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Brothers # Living \_\_\_\_\_\_\_\_\_ Health\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Dead \_\_\_\_\_\_\_\_\_ Cause of Death \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sisters # Living \_\_\_\_\_\_\_\_\_ Health \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Dead \_\_\_\_\_\_\_\_\_\_ Cause of Death \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Children Living \_\_\_\_\_\_\_\_\_\_\_ Ages and Health \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Children Dead \_\_\_\_\_\_\_\_\_\_\_ Ages and Causes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please circle illnesses which occurred in any of your Blood Relatives.

Diabetes Cancer Bleeding Tendency Kidney Disease Tuberculosis

Heart Disease Stroke High Blood Pressure Nervous Illness Arthritis

Please circle illnesses or condition you have had.

Diabetes Glaucoma Heart Trouble Hypertension Vein Trouble

Cancer Asthma Jaundice Arthritis Bleeding Tendency

Ulcers Pneumonia Kidney Disease Rheumatic Fever Nervous Disorder

Previous Operations: Please list, giving year, and hospital where performed. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Have you had serious injuries, broken bone, etc.? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ List:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had allergy or sensitivity to medicine or other substances? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use Tobacco now? \_\_\_\_\_\_\_\_ In the past? \_\_\_\_\_\_\_\_ Daily amount? \_\_\_\_\_\_\_\_\_\_ How long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol use per week if any: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you taken cortisone type drugs? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Oral Contraceptives? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your main medical problem at the present time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List current medications, dose and frequency? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Name of referring physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If not referred, would you like a report sent to your family physician \_\_\_\_\_\_Yes \_\_\_\_\_No

Name of family physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LAFAYETTE ARTHRITIS AND ENDOCRINE CLINIC

PATIENT CONFIDENTIALITY QUESTIONNAIRE

***Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**1. Can confidential messages be left on your telephone answering machine?**

**YES\_\_\_\_\_\_\_\_\_\_ NO\_\_\_\_\_\_\_\_\_\_**

**2. Please print the telephone number(s) where you want to receive calls about your appointments, lab results, x-ray results and other health care information if other than your home phone number. (This could be a work number or cellular number.)**

*\*I am fully aware that a cell phone is not a secure and private line*.

**(\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**3. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations).**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**4. If the patient is under the age of 18, please list all family members who will be allowed to request medical services for and/or accompany the patient when receiving medical services. (If someone other than the individual(s) listed below accompanies the patient in the future, a note from a parent or guardian must accompany that individual.)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I am fully aware that my health care information can be transmitted by electronic transmission, by fax transmittal, by internet or by e-mail.**

**I understand that this information is effective with the date of signing and that changes in this information will require completion of a new form and are my responsibility.**

**Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Guardian if under age 18 years)**

Lafayette Arthritis and Endocrine Clinic

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

I understand that, under the Health Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information can and will be used to:

**a.** Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who

may be involved in that treatment directly and indirectly.

**b**. Obtain payment from third-party payers.

**c.** Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

**Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

OFFICE USE ONLY

I attempted to obtain the patient’s signature in acknowledgement of the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

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

Employee Printed Name Employee Signature

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

Date

Lafayette Arthritis and Endocrine Clinic

Authorization to Release Information

I hereby authorize Lafayette Arthritis and Endocrine Clinic, or any holder of medical information about me to release to the Health Care Financing Administration and Its agents (Medicare) or Insurance Companies or Third Parties, any information needed to determine these benefits or the benefits payable for related services.

Assignment of Benefits

I request that authorized Medicare or Insurance payments of medical benefits be made to Lafayette Arthritis and Endocrine Clinic (to be used only if necessary to file claims).

Guarantor Responsibility

I understand that I am ultimately responsible for payment of any and all charges for medical services rendered by Lafayette Arthritis and Endocrine Clinic, and if this assignment is rejected, modified, or not paid within a reasonable time after it has been filed, it will be my responsibility to pay any unpaid charges in full. If it is necessary to collect unpaid fees for services rendered, I agree to pay the charge assessed by the collection service, legal counsel or court.

This authorization and assignment may be revoked by me at any time by a written notice. I agree that a photocopy of this form may be used in lieu of the original.

Acknowledgment of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have received the Notice of Privacy Practices, describing the privacy practices and safeguard as well as my right with respect to my protected health information maintained and used by Lafayette Arthritis and Endocrine Clinic.

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

Signature of Insured/Patient Date

\*PLEASE PRINT\* Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT INFORMATION**

PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LAST FIRST MIDDLE

MALE\_\_\_\_ FEMALE\_\_\_\_ \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_

SEX DATE OF BIRTH S.S NUMBER

**GUARANTOR INFORMATION**

GUARANTOR NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP CODE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOME PHONE: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WORK/CELL: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EXT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIMARY INSURANCE**

INSURANCE TYPE: Medicare Medicaid Medigap Workers Comp Group Individual

Commercial Litigation Supplement Long Term Auto Other: \_\_\_\_\_\_\_\_\_\_\_

IC#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CARRIER NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CARRIER PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT RELATIONSHIP TO SUBSCRIBER

(CIRCLE ONE):

1 Male Patient is subscriber

2 Female Patient is subscriber

3 Male Spouse of subscriber

4 Female Spouse of subscriber

5 Male Child of subscriber

6 Female Child of subscriber

7 Other:

CARRIER ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SUBSCRIBER INFORMATION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LAST NAME FIRST NAME MIDDLE INITIAL

MALE\_\_\_\_ FEMALE\_\_\_ \_\_\_\_\_\_\_/\_\_\_\_\_\_/ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SEX DATE OF BIRTH S.S.NUMBER

MAIL CLAIM TO: (CIRCLE ONE) INSURANCE CO. EMPLOYER PATIENT

EMPLOYER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMPLOY PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INS. POLICY#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ INS. GROUP# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECONDARY INSURANCE**

INSURANCE TYPE: Medicare Medicaid Medigap Workers Comp Group Individual

Commercial Litigation Supplement Long Term Auto Other: \_\_\_\_\_\_\_\_\_\_\_

IC#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CARRIER NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CARRIER PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT RELATIONSHIP TO SUBSCRIBER

(CIRCLE ONE):

1 Male Patient is subscriber

2 Female Patient is subscriber

3 Male Spouse of subscriber

4 Female Spouse of subscriber

5 Male Child of subscriber

6 Female Child of subscriber

7 Other:

CARRIER ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SUBSCRIBER INFORMATION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LAST NAME FIRST NAME MIDDLE INITIAL

MALE\_\_\_\_ FEMALE\_\_\_ \_\_\_\_\_\_\_/\_\_\_\_\_\_/ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SEX DATE OF BIRTH S.S.NUMBER

MAIL CLAIM TO: (CIRCLE ONE) INSURANCE CO. EMPLOYER PATIENT

EMPLOYER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMPLOY PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INS. POLICY#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ INS. GROUP# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY INFO: A friend or relative (Not responsible party)**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY, STATE, ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OFFICE USE ONLY-DO NOT WRITE BELOW THIS LINE**

REFERRING DOCTOR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ REF DR #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PATIENT #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LAEC DOCTOR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DR #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PATIENT TYPE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History Update**

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past Medical History: Indicate Diagnosis with X

\_\_\_\_Anemia

\_\_\_\_Adrenal Failure \_\_Adrenal Mass

\_\_\_\_Anxiety/Depression

\_\_\_\_Arthritis \_\_\_\_Rheumatoid \_\_\_\_Osteoarthritis

\_\_\_\_Alcoholism

\_\_\_\_Blood Clot/PE

\_\_\_\_Broken Bones

\_\_\_\_Cancer (type)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Diabetes

\_\_\_\_Digestive

\_\_\_\_Acid Reflux \_\_\_\_Ulcer \_\_\_\_Gallstones

\_\_\_\_Foot Ulcers

\_\_\_\_Fibromyalgia

\_\_\_\_Heart Arrhythmia

\_\_\_\_Heart Attack/MI

\_\_\_\_Heart Failure

\_\_\_\_Hemochromatosis

\_\_\_\_High Blood Pressure

\_\_\_\_High Cholesterol

\_\_\_\_High Triglycerides

\_\_\_\_Kidney Disease

\_\_\_\_Liver Disease

\_\_\_\_Lung Disease

\_\_\_\_Asthma \_\_\_\_COPD/Emphysema \_\_\_\_TB

\_\_\_\_Osteoporosis

\_\_\_\_Prostate Disease

\_\_\_\_Sarcoidosis

\_\_\_\_Sickle Cell

\_\_\_\_Sleep Apnea

\_\_\_\_Stroke

\_\_\_\_Thyroid Disease

\_\_\_\_Hyperthyroid \_\_\_\_Hypo \_\_\_\_Thyroid Nodules

\_\_\_\_Thyroid Cancer

\_\_\_\_Vision Problems

\_\_\_\_Cataract \_\_\_\_Glaucoma \_\_\_\_Retinopathy

Surgical History: Indicate with X and Date

Date (month/year-if known)

\_\_\_\_Abdominal \_\_\_\_\_/\_\_\_\_\_

\_\_\_\_Colon \_\_\_\_\_/\_\_\_\_\_

\_\_\_\_Hernia \_\_\_\_\_/\_\_\_\_\_

\_\_\_\_Appendicitis \_\_\_\_\_/\_\_\_\_\_

\_\_\_\_Gallbladder \_\_\_\_\_/\_\_\_\_\_

\_\_\_\_Brain Surgery \_\_\_\_\_/\_\_\_\_\_

\_\_\_\_Parathyroid Surgery \_\_\_\_\_/\_\_\_\_\_

\_\_\_\_Pituitary \_\_\_\_\_/\_\_\_\_\_

\_\_\_\_Brain Tumor \_\_\_\_\_/\_\_\_\_\_

\_\_\_\_Heart Surgery \_\_\_\_\_/\_\_\_\_\_

\_\_\_\_Bypass \_\_\_\_\_/\_\_\_\_\_

\_\_\_\_Stents \_\_\_\_\_/\_\_\_\_\_

\_\_\_\_Valve Replacement \_\_\_\_\_/\_\_\_\_\_

\_\_\_\_Vascular Surgery \_\_\_\_\_/\_\_\_\_\_

\_\_\_\_Vein Stripping \_\_\_\_\_/\_\_\_\_\_

\_\_\_\_Aneurysm Repair \_\_\_\_\_/\_\_\_\_\_

\_\_\_\_Neck Surgery \_\_\_\_\_/\_\_\_\_\_

\_\_\_\_Thyroid \_\_\_\_\_/\_\_\_\_\_

\_\_\_\_Parathyroid \_\_\_\_\_/\_\_\_\_\_

\_\_\_\_Lung Surgery \_\_\_\_\_/\_\_\_\_\_

\_\_\_\_Joint/Bone Surgery \_\_\_\_\_/\_\_\_\_\_

\_\_\_\_Neck \_\_\_\_\_/\_\_\_\_\_

\_\_\_\_Back \_\_\_\_\_/\_\_\_\_\_

\_\_\_\_Shoulder \_\_\_\_\_/\_\_\_\_\_

\_\_\_\_Knees \_\_\_\_\_/\_\_\_\_\_

\_\_\_\_Hip \_\_\_\_\_/\_\_\_\_\_

\_\_\_\_Foot \_\_\_\_\_/\_\_\_\_\_

\_\_\_\_Tonsils/Adenoids \_\_\_\_\_/\_\_\_\_\_

\_\_\_\_GYN/ Urinary \_\_\_\_\_/\_\_\_\_\_

\_\_\_\_Kidney \_\_\_\_\_/\_\_\_\_\_

\_\_\_\_Hysterectomy \_\_\_\_\_/\_\_\_\_\_

\_\_\_\_Breast \_\_\_\_\_/\_\_\_\_\_

\_\_\_\_Bladder \_\_\_\_\_/\_\_\_\_\_

\_\_\_\_Prostate \_\_\_\_\_/\_\_\_\_\_

\_\_\_\_Eye Surgery \_\_\_\_\_/\_\_\_\_\_

\_\_\_\_Laser \_\_\_\_\_/\_\_\_\_\_

\_\_\_\_Cataract \_\_\_\_\_/\_\_\_\_\_

**Medical History Update**

*GYN and Obstetrical*

\_\_\_\_# of live births \_\_\_\_\_\_\_\_\_Last menstrual period\_\_\_\_polycystic ovaries

\_\_\_\_# of pregnancies

Recent Hospitalizations: month/year and diagnosis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Please indicate status of immediate family: A-alive D-deceased (age of death)

Father\_\_\_\_\_\_\_\_\_ Mother \_\_\_\_\_\_\_\_\_ Sisters (how many) \_\_\_\_\_\_\_\_ Brothers (how many) \_\_\_\_\_\_\_\_\_\_

Children\_\_\_\_\_\_\_\_\_

*Family History: (Place M, F, S, C where applicable)*

(M-mother, F-father, S-sibling, C-child)

\_\_\_\_Cancer (type) \_\_\_\_\_\_\_ \_\_\_\_ Diabetes \_\_\_\_Heart Disease \_\_\_\_Hemochromatosis

\_\_\_\_High Cholesterol \_\_\_\_Hypertension \_\_\_\_Osteoarthritis \_\_\_\_Mental Illness

\_\_\_\_Kidney Disease \_\_\_\_Lupus \_\_\_\_Osteoporosis \_\_\_\_Stroke

\_\_\_\_Rheumatoid Arthritis \_\_\_\_Thyroid Disease \_\_\_\_Thyroid Cancer \_\_\_\_Depression

*Social History (Please circle)*

Married Single Divorced Widowed

Tobacco Status: (Check all that apply)

\_\_\_\_Nonsmoker \_\_\_\_Smoker \_\_\_\_Former Smoker

Product:

\_\_\_\_Cigarettes \_\_\_\_Chew \_\_\_\_Pipe

How much/often do you exercise? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you used recreational drugs? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If so, which ones? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol: (Please circle that which applies)

\_\_\_\_no alcohol \_\_\_\_Drinks/ounces daily/weekly/month

Number of Children\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Live alone \_\_\_\_\_\_\_\_\_\_\_\_ With family \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*LIST ALL PHYSICIANS THAT YOU SEE REGULARLY*

PHYSICIAN SPECIALTY LOCATION (city or town)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PRIMARY CARE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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

*Vaccines*

Flu (date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pneumonia (year) \_\_\_\_\_\_\_\_\_\_ Shingles (year)\_\_\_\_\_\_\_\_\_\_

Allergies: Please list medicine to which you have had a reaction\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Please list medications that you have taken in the past that have caused side effects or have not worked for you.

Medication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What happened \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Lafayette Arthritis and Endocrine Clinic

***Dr Todd Baquet***

Cancellation Policy/No Show Policy for All Appointments

**Cancellation/ No Show Policy for Doctor Appointment**

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 an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient failed to cancel and we are unable to schedule you for a visit, due to a seemingly “full” appointment book.

***If an appointment is not cancelled at least 24 hours in advance you will be charged a twenty-five dollar ($25) fee: this will not be covered by your insurance company.***

**Scheduled Appointments**

We understand that delays can happen however we must try to keep the other patients and doctors on time.

***If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.***

**Cancellation/No Show Policy for New Patients**

Due to the large block of time needed for new patients, last minute cancellations can cause problems and added expenses for the office.

***If appointment is not cancelled at least 24 hours in advance you will be charged a fifty-dollar ($50) fee: this will not be covered by your insurance company.***

**Account Balances**

We will require that patients with self-pay balances do pay their account balances to zero (0) prior to receiving further services by our practice.

Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a billing office representative with whom they can review their account and concerns.

Patients with balances over $100 must make payment arrangements prior to future appointments being made.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_/\_\_\_\_

Print Name--Patient Signature Patient/Guardian Date

Patient Account # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Office Use Only)