

Office Name: Express Life Chiropractic
Doctor(s) Name: Dr. Troy + Dr. Ashley Hayes

Practice Member Name: _____

Date of Accident: _____ Time of Accident: _____ City: _____ State: _____

Please contact YOUR car insurance company and obtain the following information.

Do you have Medical Pay on your Policy? YES NO
If Yes, coverage amount: \$1,000 \$2,000 \$5,000 \$10,000 \$ _____

Is your Medical Pay primary? YES NO

Personal Injury Claim #: _____

Personal Injury Adjuster's Name: _____

Adjusters Phone Number: _____ Extension: _____

Insurance Company Name, Address & Fax Number:

Fax Number: _____

Attorney Information

Have you retained an attorney? YES NO

Attorney Name: _____ Firm: _____

Phone Number: _____ Fax: _____

Other Driver (At Fault Driver) Insurance Information

Name: _____ Claim #: _____

At Fault Driver's Insurance Company Name & Address

Personal Injury Adjuster's Name: _____

Adjusters Phone Number: _____ Extension: _____

At Fault States: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Georgia, Idaho, Illinois, Indiana, Iowa, Louisiana, Maine, Maryland, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, Washington, West Virginia, Wisconsin & Wyoming

Express Life Chiropractic
Automobile/PI Accident or Work Comp Questionnaire

Patient's Name

Date of Birth

HR#:

Dear Patient:

This information is considered confidential. Your answers will help us determine if chiropractic care can help your condition. We will not accept your case if we do not believe your condition will respond satisfactorily to care. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Please answer all questions completely.

Please explain in detail how your accident happened: _____

What were the time and date of present injury? _____

Where did you feel pain immediately after the accident? _____

List the extent of your injuries as you know them: _____

Did you require post-accident hospitalization? ☐ Yes ☐ No

Check symptoms you have noticed since the accident:

<input type="checkbox"/> Headache	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Depression	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Light Bothers Eyes	<input type="checkbox"/> Buzzing in Ears	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Neck Pain
<input type="checkbox"/> Head Seems to Heavy	<input type="checkbox"/> Memory Loss	<input type="checkbox"/> Feet Cold	<input type="checkbox"/> Neck Stiff
<input type="checkbox"/> Pins and Needles in Arms	<input type="checkbox"/> Ears Ring	<input type="checkbox"/> Hands Cold	<input type="checkbox"/> Fainting
<input type="checkbox"/> Sleeping Problems	<input type="checkbox"/> Back Pain	<input type="checkbox"/> Face Flushed	<input type="checkbox"/> Loss of Balance
<input type="checkbox"/> Pins and Needles in Legs	<input type="checkbox"/> Constipation	<input type="checkbox"/> Tension	<input type="checkbox"/> Nervousness
<input type="checkbox"/> Numbness in Fingers	<input type="checkbox"/> Loss of Smell	<input type="checkbox"/> Fever	<input type="checkbox"/> Irritability
<input type="checkbox"/> Numbness in Toes	<input type="checkbox"/> Loss of Taste	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Cold Sweats
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Stomach Upset		

Symptoms other than above: _____

Where were you taken after the accident? _____

Hospitalized? ☐ Yes ☐ No If yes, admitted? _____ How long? _____

Name of Hospital: _____

Name of Doctor(s): _____

What treatment was given? _____

Patient's Name _____

Date of Birth _____

HR#: _____

Was any other doctor consulted after your accident? ☐ Yes ☐ No

If so, what was the doctor's name? _____ D.C., M.D., D.O., D.D.S.

What was the diagnosis? _____

What treatment was given? _____

How often did you see the doctor? _____

How long did you see the doctor? _____

Have you ever had any complaints in the involved area before? ☐ Yes ☐ No

If so, what were the complaints? _____

Before the injury were you capable of working on an equal basis with others your age? ☐ Yes ☐ No

Are your work activities restricted as a result of this accident? ☐ Yes ☐ No

Since this injury are your symptoms ... ☐ Improving? ☐ Getting worse? ☐ Same?

Driver of other vehicle (if any):

Name _____ Insurance Company _____ Policy No. _____

Driver of vehicle in which you were injured (if applicable):

Name _____ Insurance Company _____ Policy No. _____

Name of your insurance adjustor _____

Have you retained an attorney? ☐ Yes ☐ No

If so, his/her name and address _____

You were heading North/ East/ South/ West on _____ (street or highway)

Other vehicle was heading North/ East/ South/ West on _____ (street or highway)

Were police notified? ☐ Yes ☐ No

Were you knocked unconscious? ☐ Yes ☐ No If yes, for how long? _____

You were struck from Behind/ Front/ Left Side/ Right Side _____

You were Driver/ Passenger/ Front seat/ Back Seat/ Using seat belts _____

Patient Signature _____

Date _____

Doctor Signature _____

Date _____

ACTIVITIES OF DAILY LIVING

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

<u>ACTIVITY:</u>	<u>EFFECT:</u>			
Carrying Groceries	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sit to Stand	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Climbing Stairs	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Pet Care	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Extended Computer Use	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Household Chores	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Lifting Children	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dressing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Shaving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sexual Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sleep	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Washing/Bathing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sweeping/Vacuuming	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dishes	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Laundry	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Yard work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Garbage	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Concentration (Reading)	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Other: _____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Other: _____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform

Signature: _____ Date ____ / ____ / ____

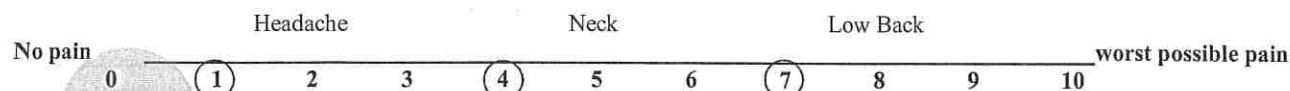
QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

1 – What is your pain RIGHT NOW?

2 – What is your TYPICAL or AVERAGE pain?

3 – What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?

4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?

OTHER COMMENTS:

Examiner _____

PERSONAL INJURY LIEN

Patient Name: _____

Date of Accident: _____

I hereby authorize and direct:

Name of Attorney: _____

Attorney's Address: _____

Attorney's Phone: _____

Attorney's Signature: _____

to pay directly to Express Life Chiropractic such sums as may be due and owing for treatment rendered to me, both by reason of this accident and by reason of any other bills that are due to Express Life Chiropractic to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately give a lien on my case any and all proceeds of any settlement, the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to Express Life Chiropractic for all medical bills submitted for services rendered to me and that this agreement is made solely for Express Life Chiropractic for additional protection and in consideration of awaiting payment. I further understand that such payment is to eventually recover said fee.

Patient's Signature

Date

Countersigned/Witnessed by Staff

Date

**ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE PERSONAL INJURY, WORK COMP, ERISA,
AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND /OR
HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND
DESIGNATION OF AUTHORIZED REPRESENTATIVE**

Provider Name: Dr. Troy Hayes D.C.

Clinic: Express Life Chiropractic

Address: 8550 Andermatt Dr. Ste 2 Lincoln, NE 68526

I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, any and all medical benefits and/or any insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of all medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort feisor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Patient Signature

Date

EXPRESS LIFE CHIROPRACTIC HEALTH PROFILE

Name _____ Date ____/____/____ Age _____ Male/Female
 Address _____ City _____ State _____ Zip _____
 Phone: Home _____ Cell _____ Date of Birth ____/____/____
 Email Address _____
 For confirming appts, would you prefer? TEXT (cell carrier: _____) or EMAIL _____
 Occupation _____ Employer's Name _____
 Single / Married / Divorced / Widowed Spouse's Name _____
 Number of Children _____ Names, Ages & Gender _____

 Social Security Number _____
 Who may we thank for referring you? _____

Terms of Acceptance

In order to provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic:

- A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
- B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.
- C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day doctors of chiropractic in the United States alone.
- D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
- E. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
- F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic.
- G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

By my signature below, I have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

 (Signature)

 (Date)

Notice of Privacy Practices Acknowledgement

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

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physician's certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclosed to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

(Signature)

(Date)

Personal Injury/Auto Accident/Workers Comp. Policies and Fee Schedule

- o **Consultation**- includes practice member history. This service is complimentary
- o **Assessment (new or established practice member)**- includes one or more of the following: thermography, orthopedic/neurological evaluation, range of motion, motion and/or static palpation, leg check \$250-\$320.
- o **Chiropractic Adjustment**- The actual re-alignment of the vertebra done by hand and/or instrument. Often a sound will be heard, but if there is no auditory result, it does not mean that the adjustment has not taken place. \$80-\$120.
- o **X-rays**- Specific x-ray views taken of your spine to determine a misalignment/subluxation of your vertebrae. These can also be used to indicate progress after period of care. \$60 per view. Reproduction of X-rays are \$15 per copy.
- o

Release of Authorization/Assignment of Benefits

I authorize and request payment of insurance benefits directly to Troy Hayes, D.C. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance.

A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the practice member's insurance at the time of service. Your health/auto insurance company will only pay for services that it determines to be "reasonable and necessary." Every effort will be made by this office to have all services and procedures pre authorized by your health/auto insurance company. If your health insurance company determines that a particular service is not reasonable and necessary, or that a particular service is not covered under the plan, your insurer will deny payment for that service. If my health/auto insurance company denies payment (in whole or in part), I understand that I am personally and fully responsible for payment. I also understand that if my health/auto insurance company does make payment for services, I will be responsible for any co-payment, deductible, out of pocket, or coinsurance that applies.

I understand that I am financially responsible for charges not covered by this assignment.

Signature_____

Date_____

INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS LEVEL OF RISK IS MOST OFTEN VERY MINIMAL, YET IN RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THE TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SECONDARY TO CHIROPRACTIC CARE INCLUDE: SPRAIN/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC CARE OCCURRING AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO ONE PER TWO MILLION CERVICAL SPINE (NECK) ADJUSTMENTS MAY BE A VERTEBRAL INJURY THAT COULD LEAD TO A STROKE.

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND IN PARTICULAR YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NEEDED, OR IF ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY AND THE CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

PRINT PRACTICE MEMBER'S NAME HERE

PRACTICE MEMBER'S SIGNATURE

DATE

IF PRACTICE MEMBER IS A MINOR/CHILD, PARENT OR GUARDIAN MUST SIGN BELOW.

SIGNATURE OF PRACTICE MEMBER OR GUARDIAN

DATE

RELATIONSHIP TO MINOR/CHILD

WITNESS SIGNATURE (OFFICE STAFF)

DATE

XRAY AUTHORIZATION

AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC RECORDS. WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES.

AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A COPY OF YOUR X-RAYS IN OUR FILES. HOWEVER, THE REPRODUCTION OF X-RAYS THERE WILL BE \$15 SURCHARGE FOR THE DUPLICATION OF X-RAYS.

PLEASE NOTE: IF CLINICALLY NECESSARY X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE VERTEBRAL SUBLUXATIONS. THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTORS OF EXPRESS LIFE CHIROPRACTIC DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS; HOWEVER, IF ANY ABNORMALITIES ARE FOUND, WE WILL BRING IT TO YOUR ATTENTION SO THAT YOU CAN SEEK PROPER MEDICAL ADVICE.

BY SIGNING BELOW, YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS.

PRINT YOUR NAME HERE _____

DATE _____

SIGNATURE _____

YOUR AGE _____

**FEMALE PATIENTS ONLY: TO THE BEST OF MY KNOWLEDGE, I BELIEVE I AM NOT PREGNANT
AT THE TIME X-RAYS ARE TAKEN AT EXPRESS LIFE CHIROPRACTIC.**

SIGNATURE _____

DATE _____

• DO NOT WRITE BELOW THIS LINE

For Office Use Only:

Notes;

X-rays: _____ PDR Date: _____ CA Initials: _____