MRN #:\_\_\_\_\_\_\_\_\_  **Daniel Clinic Patient Registration** EMP. \_\_\_\_\_\_\_\_

(Please PRINT)

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient Information** | | | | | | | | | | | | | | | | |
| Last Name: | | First Name: | | | | | | M.I.: | | | | | | Preferred Name: | | |
| Mailing Address: Apt #: | | | | | | | | | | | | | | | | |
| Physical Address: | | | | | | | | | | | | | | | | |
| City/State/Zip: | | | | | | | | | | | | | | | | |
| Home Phone: | | | Cell Phone: | | | | | | | | | | Work Phone: | | | |
| Preferred Method of Contact for Reminder Calls and Other Electronically Generated Messages:  (Please Select Only One Option) Voice Text | | | | | | | | | If Voice, Please Select Preferred Number:  Home Cell Work | | | | | | | |
| Primary Care Provider or Pediatrician: | | | | Date of Birth: | | | | | | | | | | | Sex:  Male Female | |
| Marital Status: | | | | Social Security Number: | | | | | | | | | | | US Military/Veteran:  No Yes | |
| Employer Name: | | | | Employer Contact Name: | | | | | | | | | | | | |
| Emergency Contact: | | | | Phone #: | | | | | | | | Relationship to Patient: | | | | |
| **Responsible Party**- If the patient is a minor (under the age of 18), the parent of guardian bringing the patient in will be listed as the guarantor. | | | | | | | | | | | | | | | | |
| Last Name: | | | | | | First Name: | | | | | | | | | | |
| Date of Birth: | Social Security #: | | | | | | | | | | Phone #: | | | | | |
| Address of Person Responsible: | | | | | | | | | | | | | | | | |
| City/State/Zip: | | | | | | | | | | Relationship to Patient: | | | | | | |
| Additional Information **(PLEASE FILL OUT ALL SECTIONS BELOW)** | | | | | | | | | | | | | | | | |
| Email Address: | | | | | | | Can we leave a message regarding your medical care & test results?  Yes No | | | | | | | | | |
| Race (select one):  White American Indian or Alaska Native Asian  Hispanic Black or African American Native Hawaiian or Pacific Islander  Other Decline | | | | | | | Ethnicity (please select one):  Hispanic or Latino  Not Hispanic or Latino  Decline | | | | | | | | | Religion (please select one):  Catholic Pentecostal  Baptist Other  Methodist |
| Preferred Language (please select one): English Bosnian Indian (including Hindi& Tamil)  Sign Language Spanish Russian Other | | | | | | | | | | | | | | | | |
| Preferred Pharmacy Name & Location: | | | | | | | | | | | | | | | | |
| **Primary Insurance** | | | | | **Secondary Insurance** | | | | | | | | | | | |
| Insurance Company Name: | | | | | Insurance Company Name: | | | | | | | | | | | |
| Policy Holder Name: | | | | | Policy Holder Name: | | | | | | | | | | | |
| Policy Holder’s Date of Birth: | | | | | Policy Holder’s Date of Birth: | | | | | | | | | | | |
| Policy Holder’s Social Security Number: | | | | | Policy Holder’s Social Security Number: | | | | | | | | | | | |
| Patient Relationship to Policy Holder: | | | | | Patient Relationship to Policy Holder: | | | | | | | | | | | |
| I certify that I have read and agree to Daniel Clinic’s Payment Policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I herebyassign to Daniel Clinic all money to which I am entitled for medical expenses related to the services performed from time to time by Daniel Clinic, but not the exceed my indebtedness to Daniel Clinic. I authorize Daniel Clinic to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A $25.00 returned check fee will be charged for checks returned due to insufficient funds. I choose to receive communications from Daniel Clinic by text or e-mail at the number or address stated above, including but not limited to communications about appointments, treatment, and payment. I understand that such e-mails and texts may not be secure and there is a risk that they may be read by a third party. | | | | | | | | | | | | | | | | |

**I have reviewed/received a copy of Daniel Clinic’s Privacy Policy Notice. (Initials)**

**Signature of Responsible Party: x\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed Name of Responsible Party: x\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Child’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Child’s Past Medical History**

***Pregnancy/Neonatal Period***

Where was your child born? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the child yours by birth adoption stepchild other

Pregnancy complications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Delivery by vaginal c-section

Reason for c-section \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Complications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was your child premature No Yes, born at \_\_\_\_\_\_\_\_\_ weeks

Complications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Apgar Scores 1 minute \_\_\_\_\_\_\_\_\_\_\_\_\_ 5 minutes \_\_\_\_\_\_\_\_\_\_\_\_\_

Birth weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Length \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other problems in the newborn period \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

***Infancy/Childhood/Adolescence***

Has your child ever been treated for or diagnosed with: (explain)

Asthma or reactive airway disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Wheezing or bronchiolitis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Seasonal allergies or eczema \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food Allergy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recurrent ear infections \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pneumonia \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Urinary tract infections \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Genetic syndrome \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Seizures \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anemia \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Broken Bones \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mental retardation or learning disability \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Depression/anxiety \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other chronic medical conditions \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Has your child ever been hospitalized No Yes (explain)

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

Previous surgeries and dates \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Please list any specialist your child is currently seeing and reason:\_\_\_

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

***Medications***

**ALLERGIES** to medicine/vaccines (list and describe reaction)

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

Current medications and dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Vitamins\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Herbal Supplements \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Over-the-counter meds \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Development/Nutrition***

At what age did your child: 1st period (females)\_\_\_\_\_\_\_

Walk alone\_\_\_\_\_\_\_\_\_\_\_\_\_ Sit alone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Toilet train (day)\_\_\_\_\_\_\_\_\_ Say words \_\_\_\_\_\_\_\_\_\_\_\_\_

Was your child breastfed No Yes, How long? \_\_\_\_\_\_\_\_\_\_

Has your child had any unusual feeding/dietary problems? Explain.

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

Current milk intake: Type:\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount\_\_\_\_\_\_\_\_\_\_\_oz/d

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History**

Who lives in the household with the child? Mom Dad

Siblings (#\_\_\_\_\_\_\_) Grandparents Other \_\_\_\_\_\_\_\_\_

Child’s parents are married unmarried divorced other

Childcare parents relatives daycare babysitter/nanny

Days per week in childcare (not with parents) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do any household members smoke Yes No

How many hours per day does your child spend:

Watching TV\_\_\_\_\_\_\_ Computer \_\_\_\_\_\_\_Video games\_\_\_\_\_\_\_

Child’s school name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Grade\_\_\_\_\_\_\_\_\_\_\_\_

Any concerns about school performance? No Yes, explain

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

Any concerns about peer or teacher relationships? No Yes

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

Sports/exercise: Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long? \_\_\_\_\_\_\_\_\_\_\_min

**Family History**

Do any family members have any of the following conditions?

**Condition Mother Father Sibling Grandparents**

Asthma

Anemia

Blood disorder

Cancer

Heart attack/disease

High cholesterol

High blood pressure

Stroke

Diabetes

Thyroid disease

Kidney disease

Seizures

Migraines

Depression/anxiety

Alcoholism

ADD/ADHD

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

Please explain all positives: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Review of Systems** (check all that apply)

***Constitutional******Gastrointestinal***

Fever/chills Fatigue Nausea, vomiting, diarrhea

Unexplained weight loss/gain Constipation, blood in stool

Excessive thirst Abdominal pain

***Ear, Nose, & Throat******Cardiovascular***

Loud voice, hearing problem Chest pain, palpitations

Mouth-breathing, snoring Tires easily with exertion

Ear pain Fainting

Frequent runny nose

***Respiratory******Genitourinary***

Cough, short of breath Frequent or painful urination

Chest tightness, wheeze Bedwetting/frequent accident

Vaginal or penile discharge

***Musculoskeletal*** *Neurologic*

Muscle pain, weakness Headaches Milestone delay

Joint pain, swelling Clumsiness Seizures

Bone pain ***Psychiatric/Emotional***

***Other (eye,skin,blood)*** Anxiety/stress Depression

Blurry vision Squinting Sleep problem

“Crossed” eyes Itchy eyes Concerns with attention

Rashes Abnormal moles Anger concern

Abnormal bruising, bleeding

Daniel Clinic

5326 Oak St / PO Box 487

St. Francisville, LA 70775

Ph #: 635-5848 Fax #: 635-5847

AUTHORIZATION FOR INDIVIDUALS INVOLVED

IN THE CARE OF THE PATIENT

Patient’s Name: DOB:

From time to time it may be necessary for individuals other than the parent(s) or legal guardian(s) of a patient to accompany the patient to our office. In such cases, the patient’s parent(s) or legal guardian(s) must formally designate the individual(s) who have been asked to serve on behalf of the parent(s) or legal guardian(s). If you wish to designate such an individual, please complete the following:

In my absence, I authorize the following individual(s) to act on my behalf in allowing the patient to receive medical treatment, including lab work, injections, treatments or procedures, etc., deemed necessary for the patient. At the time of service, medical and/or billing information may be released to the individual present with the patient.

It is the responsibility of the patient’s parent(s) or legal guardian(s) to keep this form updated with any additions and/or deletions. I understand that this consent will remain in effect until I request otherwise in writing.

Authorized Person(s)’ Names

(Please Print)

Parent’s/Legal Guardian’s Name (Print)

Parent’s/Legal Guardian’s Signature

Effective Date:

Relationship To The Patient

(Please Print)

Date

Discontinue Date:

Authorization for Release of Protected Health Information

(Records over 25 pages should be mailed)

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

Guardian’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

**\*If patient is under 18 years of age\***

**Release Information from:**

**Doctor/Clinic’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Release to:** Daniel Clinic

**Purpose of Disclosure:**  Medical Care Legal Insurance Personal Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Description of Information to be Used or Disclosed:**  Complete Information Visit Notes Labs/Radiology Verbalized

Other/Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I acknowledge, and hereby consent to such, that the released information may contain genetic test results, alcohol/drug abuse, psychiatric, HIV testing, HIV results or AIDS information.
4. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
5. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
6. I understand that I may see and obtain a copy of the information described on this form if I ask for it.
7. I may get a copy of this form after I sign it.

**Signature of Patient/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_**

**Relationship to Patient:** Self  Mother Father Child Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This authorization will expire on: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_. If I fail to specify an expiration date, this authorization will expire six months from the date on which it was signed.

Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

**\*For Employee\***

Daniel Clinic

5326 Oak St/PO Box 487

St. Francisville, LA 70775

Phone: 225-635-5848

Fax: 225-635-5847