Edward Dieguez Jr., MD
811 State Road 206 East
South Shore Plaza, Ste. #1
Saint Augustine, Florida 32086
Phone: (904) 824-0955 Fax (904) 824-2226
E-mail: info@WellnessAndRegenerativeMD.com
www.WellnessAndRegenerativeMD.com

Letter to Prospective Patients

Thanks for your interest in wanting to become a patient in our office. **To expedite your appointment,** it is important that you follow the instructions on this page and on the accompanying forms. Our goal is to provide our patients **timely appointment** and make your visit to our office a pleasant one **without undue delays or long waits**. You will be seen at the scheduled time so we ask that you arrive to our facility 15 minutes prior to your appointment time.

1. This **Prospective Patient Information Packet** consists of ten sections . By collecting this information prior to your visit to our office, we are able to carry out a more complete evaluation of your medical problems while at the same time **allowing the doctor to spend more time face to face with you, the patient, during the visit.** By answering any questions you may have and by explaining to you in detail all the ins and out of your condition, in addition to the treatment that he recommends, you will not feel like you are being rushed and that you are not being listened to. **Our goal when you visit our office is to make your experience unlike any other you may have had at a doctors office. Additionaly we do not want our patients to just sit and wait for hours on end in our waiting room. So please be on time.**

2. In order for Dr. Dieguez to make an accurate initial assessment of your condition, all questions must be answered in full, with all spaces completed. If you do not have, or know, the information requested, please indicate so.

3. Enter your name, signature, and date, as indicated, **on all the appropriate spaces in the forms.**

4. Once you have completed all sections, return them to us as soon as possible and we will call you to arrange a date and time that is convenient to you for your appointment at our office. **Our goal is to get you in as soon as possible. We will strive to get you in ASAP, schedule permitting or even the same day you call us.**

Sincerely,

Administrative Cordinator

Edward Dieguez Jr., MD

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Our Philosophy.- This is how we see it: NO INSURANCE? NO PROBLEM! DO YOU HAVE AN INSURANCE POLICY THAT RESTRICTS YOUR ACCESS TO SPECIALIST CARE? NO PROBLEM! WE CAN HELP! WE HAVE AFFORDABLE FLAT RATES FOR YOU! We realize that with the introduction of the "Affordable Care Act", some patients out there are still finding it difficult to afford health insurance coverage. Others are now facing much higher deductibles and co-pays. Still other have insurance policies that makes it very difficult or impossible for them to have access to specialist care and can only see a specialist if they are referred by their primary care physician. DO YOU THINK THAT THIS IS REALLY GOING TO HAPPEN ANYTIME SOON? NOT A CHANCE. Do you know why? Because these primary care physicians are incentivized by your insurance company not to make those referrals, because it increases the insurance company's cost to provide your care. So you find yourself with a condition that necessitates specialist care and you are not getting it when you want it.

Issues you may be facing! 1.No insurance? 2.High insurance deductibles? 3.Want better care not provided by your insurance? 4.High co-pays? 5.Delaying tactics by your insurance company? 6.Access to specialist care made difficult by your insurance company or primary care doctor running an HMO? 7.Insurance that not many offices accept?

We understand these issues that **many patients are facing** and we wanted to **do what we can to help.** Hopefully these issues will be solved soon for everyone but in the mean time **we are here** trying to do the best we can to help you.

Our solutions! Wanting to avoid turning down those patients in our office, prompted us to come up with some kind of affordable solution for ***patients with financial hardship*.** You will need to sign some forms and a financial hardship agreement to take advantage of these affordable rates.

1.- **Flat cash affordable rates** for everyone facing the above mentioned issues if we are not participating provider with your insurance company. Examples that come to mind are Humana, GHI, Aetna, Cigna, AvMed, EHN, Connecticut General, Coventry Health, Capital Health Plan, CarePlus Health Plan, Health First Plans, Prime HealthCare, Sunshine State Health Plan, Florida Health Care Plan, Tricare HMO, Wellcare, and many, many others.

2.- **For those other procedures** more specialized that we offer in our office, such as Prolotherapy, PRP, and BMC Stem Cell Procedures, that **have never been covered by insurance companies**, we have also tried to **keep them affordable** for you and **have adjusted our price much lower than the competition**. These specific procedure are never cheap because they are time consuming and supplies are pricy.

Call our office to get additional information.

It is important that you are aware that we will not be providing chronic controlled substance prescriptions just because you are paying cash. Some offices out there may do that. We do not! If this is what you are looking for, you need to go elsewhere. We are not one of those so called " pill pain clinic".

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SOURCES OF INFORMATION ABOUT OUR PRACTICE

In our constant effort to keep you informed about new development and new treatment option that we offer at our office we have created **two sources** of information for you. We kindly request, that you look at these sources of information and share them with friends and family.

1. - **The first one is our Office Facebook Page.** Here we add information at least weekly and also our patient can ask questions, rate our services and stay in contact with new developments or any events planned at our office. Please we encourage you to visit us on the web at: **www.Facebook.com/WellnessAndRegenerativeMD.com.** Visit us and tell us what you think. Look around the site, as we have posted several videos that may interest you. Share with friends and family member that you think may be interested in some of the conditions and the treatment we provide. Please rate us so we know how we are doing or if we need to change anything. Your comments will be greatly appreciated.

2. - **The second one is our Office Website.** Here you will get an overview of the different modalities of treatments that we offer and different conditions we treat at our office. You will also find an area in our website where you can request appointments at our office. Visit us at: **www.WellnessAndRegenerativeMD.com**.

3.- Please be aware that **we are not** one of those so called **"pain clinics"** and we do not prescribe chronic narcotic medications. With that been said, **if what you are looking for are narcotics or other controlled substances, don't expect to get them in this office.** Don't waste my time or yours. Or your money for that matter! This is not a pain clinic. Here you will go out empty handed. And remember, we will not hesitate in reporting drug seekers to the authorities if we have to. **We do not prescribe Marijuana or any of its derivatives either!**

Sincerely,

Edward Dieguez Jr. M.D.

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Section 1 - General Information/Patient registration

Important Note: Please understand that all questions must be answered in full if possible, with all spaces completed, in order to expedite the process for an appointment. If the information requested is not available please specify so. **Please print clearly.**

1) PATIENT'S FULL NAME: _____

DATE OF BIRTH: _____ (MM/DD/YY) SOCIAL SECURITY NUMBER: _____

2) MAILING ADDRESS: _____

CITY AND STATE: _____ ZIP: _____

**** CURRENT E-MAIL ADDRESS:** _____

3) HOME PHONE (INCLUDING AREA CODE): _____

WORK PHONE (INCLUDING AREA CODE): _____

MOBILE PHONE (INCLUDING AREA CODE): _____

4) MARITAL STATUS: SINGLE _____MARRIED _____DIVORCED _____OTHER _____

5) PERSON TO CONTACT IN EMERGENCY_____

PHONE NUMBER (INCLUDING AREA CODE) _____

RELATIONSHIP TO PATIENT _____

6) ARE THE SERVICES YOU WISH TO OBTAIN FROM THE DOCTOR ACCIDENT RELATED? YES ____ NO ____

7) ARE YOU EMPLOYED? YES ____ NO ____ IF YES, SPECIFY WHERE:

_____

8) IF MARRIED, IS YOUR SPOUSE EMPLOYED? YES ____ NO ____ IF YES, SPECIFY

WHERE? _____

9) **Primary Insurance Information**:

_____

INSURANCE COMPANY NAME

10) **Secondary Insurance Information**:

_____

INSURANCE COMPANY NAME

I understand that in order to have these services properly paid by my insurance company if covered, I am responsible for the accuracy of all the above information. I have answered all of the above truthfully and to the best of my ability and I understand that I am solely responsible for any misrepresentations or errors included herein. If the above information is to change at any time, I will notify this office in writing within ten days. I also understand that the answers to the above questions may have legal implications if I have intentionally supplied false or misleading information. I authorize the release of any medical records required for claim payment. I further assign all benefits payable to Edward Dieguez, Jr., M.D. P.A. Should any insurance company fail to pay these services; I assume full responsibility for any remaining balance due. Please be aware that we do not accept insurance for Acupuncture unless benefits are fully verified by our office.
Regenerative procedures such as BMC Stem Cell, Platelet Rich Plasma and Prolotherapy are never covered by insurance.

PATIENT OR RESPONSIBLE PARTY: _____
(Please print)

SIGNATURE: _____ DATE: _____
(Patient's or Responsible Party's)

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Section 2- Health Questionnaire/New Patient's Questionnaire

Patient Name: _____ Age: _____

Who referred you to our office: _____

Who is your primary care doctor: _____

(CC) What problem brings you to our office today? _____

_____

_____

HISTORY OF PRESENT ILLNESS (HPI)

Brief description of the pain to include the following:

1) Location: _____ 2) Duration: _____

3) Quality: sharp; Y N dull; Y N aching; Y N

4) Timing: gradual; Y N acute; Y N When did it start? _____

5) Modifying factors such as:

Made worse by _____

Relieved by_____

6) Context: such as when it first appeared, associated with etc. _____

_____

7) Severity: Pain score; 0 1 2 3 4 5 6 7 8 9 10

8) Does the pain * Radiates; Y N where to _____

9) Is there: * Numbness; Y N where _____

* Weakness; Y N where_____

10) How does the pain affect your daily living: _____

_____

(ROS) DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS:

(Please answer yes or no to the following)

* **GENERAL:** Generalized weakness; Yes____ No____ Weight change: Increased ____ Decreased_____

* **SKIN:** Rashes-Hives: Yes___ No____ Color Change: Yes___ No____

***HEENT: HEAD, EYES, EARS, NOSE AND THROAT**

EYES: Glaucoma: Yes____ No____ Cataracts: Yes____ No____

EARS: Ringing in ears: Yes____ No____ Loss of Hearing: Yes____No____

NOSE: Nose Bleeds: Yes____ No____ Sinus problems: Yes____ No____

THROAT: Hoarseness: Yes____ No____ Difficulty Swallowing: Yes____ No____

* **NECK:** Lumps: Yes _____ No_____ Thyroid nodules: Yes_____ No_____

* **BREASTS:** Lumps: Yes_____ No_____ Nipple discharge: Yes_____ No_____ Tenderness: Yes_____ No_____

* **RESPIRATORY SYSTEM:** Tuberculosis: Yes____ No Asthma: Yes____ No____ Emphysema: Yes____ No____

Blood when coughing: Yes____ No____ Shortness of Breath: Yes____ No____

* **HEART/ARTERIES:** Heart attack: Yes____ No____ Chest Pain: Yes____ No____ When: _____ BP: Yes____ No____

Congestive Heart failure: Yes____ No____ Rheumatic Fever: Yes____No___

Congenital Heart Disease: Yes____ No____ Heart murmur: Yes____ No____ Artificial Valve: Yes____ No____

Clogged arteries: Yes____ No_____ Aneurysm: Yes____ No____

Palpitations: Yes_____ No_____ Passing out spells: Yes_____ No_____

* **ABDOMEN/ DIGESTIVE SYSTEM:**

Jaundice: Yes____ No____ Bloody Stools: Yes____ No____ Hepatitis: Yes____ No____ Ulcers: Yes____ No____

Colon Cancer: Yes____ No___ Rectal Cancer: Yes____ No____ Gastric Bypass: Yes____ No____

Abdominal pain: Yes____ No_____ Vomiting: Yes_____ No_____ Bloody stools: Yes_____ No_____

* **GENITO-URINARY SYSTEM:** Frequent Urination: Yes____ No____ Burning: Yes____ No_____ Blood in Urine: Yes____ No____

Kidney Disease: Yes ____ No____ Urethral Discharge: Yes____ No____ Venereal Disease: Yes____ No____

Prostate cancer: Yes_____ No_____ Urinary incontinence: Yes____ No_____ Kidney Tumors: Yes____ No_____

* **BLOOD AND LYMPHATICS:** Anemia: Yes____ No____ Hemophilia: Yes____ No____ Transfusions: Yes ____ No____

HIV: Yes____ No____ Bleeding tendencies: Yes____ No____ Hematomas: Yes____No____

Lymph node enlargements: Yes____ No____

* **ENDOCRINE SYSTEM :** Diabetes: Yes____ No____ Thyroid Problem: Yes____No____ Thyroid nodules: Yes____ No_____

Goiter: Yes____ No____

* **NERVOUS SYSTEM:** Headache: Yes____ No____ Dizziness: Yes____No____ Strokes: Yes____ No____ Nerve injury: Yes____ No____

Paralysis:Yes____ No____ Tremors: Yes_____ No_____

***PSYCHIATRIC :** Hx of Depression:Yes_____ No_____ Suicidal ideation: Yes_____ No_____

Hx of Anxiety: Yes_____ No_____ Bipolar: Yes_____ No_____

***MUSCULOSKELETAL:** Tennis Elbow: Yes___ No___ Golfers elbow: Yes____ No:_____ Back surgery: Yes____ No____

Carpal Tunnel: Yes ____ No_____

* **OTHER:** Radiation Therapy:Yes____ No____ Scarlet Fever:Yes____No____

Mononucleosis:Yes____ No____ Dialysis:Yes____No____

Are you pregnant: Yes____ No____

On hormone replacement: Yes_____ No_____

Malignant Hyperthermia: Yes_____ No_____

* **ALLERGIES:** Local Anesthesia: Yes____ No_____ Penicillin: Yes____ No____

Barbiturates: Yes____ No____ Other Antibiotics: Yes____ No____

Aspirin: Yes___ No____ Codeine: Yes____No____

Latex/Rubber: Yes____ No____ Other Allergies: _____

PAST MEDICAL & SURGICAL, FAMILY AND SOCIAL HISTORY (PFSH) PLEASE WRITE ANY NEEDED EXPLANATION:

Past Surgeries (specify type and when)_____

_____

Other medical problems: _____

_____

Do you use or ever had one of the following:

Alcohol use: Yes____ No____ If so how much? _____

Smoke: Yes____ No____ How many packs per day? _____ Years smoking? _____

Do you use illegal drugs: Yes____ No____ Which ones?_____

Do you smoke marijuana: Yes____ No____

Have you ever been hospitalized with a psychiatric condition: Yes_____ No_____

Have you ever been in prison: Yes_____ No_____

Living arrangements: Live alone_____ With family_____

Are you presently employed: Yes____ No_____ Ocupation? _____

Name, address and phone number of family doctor and other doctors that treat you for

this problem or other problems at present. _____

_____

Present medications: (please list all below or add separate paper):

Name	Dosage and frequency	Purpose
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications you have tried before for your condition:_____

_____

Are currently involved in or considering a lawsuit in relation to your problem? _____

_____

Are you receiving compensation for any medical problem? _____

_____

Patient's Signature:_____ Date:_____

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Section 3 - Assessment for Patients with Pain

Following are questions given to patients in pain. Please answer each question as honestly as possible. Your treatment will not be determined solely by the answers provided. Thank you.

PATIENT: _____
(please print)

Please answer all the questions below by circling the number that most accurately matches your response. Use the following scale:

0 = Never 1 = Seldom 2 = Sometimes 3 = Often 4 = Very often

1. How often do you feel that your pain is "out of control?" 0 1 2 3 4
2. How often do you have mood swings? 0 1 2 3 4
3. How often do you do things that you later regret? 0 1 2 3 4
4. How often has your family been supportive and encouraging? 0 1 2 3 4
5. How often have others told you that you have a bad temper? 0 1 2 3 4
6. Compared to other people, how often have you been in a car accident? 0 1 2 3 4
7. How often do you smoke a cigarette within an hour after you wake up? 0 1 2 3 4
8. How often have you felt a need for higher doses of medication to treat your pain? 0 1 2 3 4
9. How often do you take more medication than you are supposed to? 0 1 2 3 4
10. How often have any of your family members, including parents and grandparents had a problem with alcohol or drugs? 0 1 2 3 4
11. How often have any of your close friends had a problem with alcohol or drugs? 0 1 2 3 4
12. How often have others suggested that you have a drug or alcohol problem? 0 1 2 3 4

13. How often have you attended an AA or NA meeting? 0 1 2 3 4

14. How often have you had a problem getting along with the doctors who prescribe your medicine? 0 1 2 3 4

15. How often have you taken medication other than the way that it was prescribed? 0 1 2 3 4

16. How often have you been seen by a psychiatrist or mental health counselor? 0 1 2 3 4

17. How often have you been treated for an alcohol or drug problem? 0 1 2 3 4

18. How often has your medication been lost or stolen 0 1 2 3 4

19. How often have others expressed concern over your use of medication? 0 1 2 3 4

20. How often have you felt a craving for medication? 0 1 2 3 4

21. How often has more than one doctor prescribed pain medication for you at the same time? 0 1 2 3 4

22. How often have you been asked to give a urine screen for substance abuse? 0 1 2 3 4

23. How often have you used illegal drugs (such as marijuana, cocaine, etc.,) in the past five years? 0 1 2 3 4

24. How often, in your lifetime, have you had legal problems or been arrested? 0 1 2 3 4

Please include any additional information you wish about the answers above. Thank you.

_____

_____

PATIENT'S SIGNATURE: _____ _____ DATE: _____

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Section 4 - Medical Records Request or Release

I, the undersigned, authorize Edward Dieguez, Jr., M.D. and his staff either to request from, or release to, any and all other entities, such as doctors, hospitals, insurance companies and medical facilities, any and all medical information related to my care. I further authorize Edward Dieguez, Jr., M.D. and his staff to discuss my medical conditions and share information with other physicians or entities that may have participated in my care in the past or that will participate in my care in the future. I also authorize Dr. Dieguez to share the information with me the patient. I understand that some of this information may be transmitted via fax machine [or by any other electronic means].

PATIENT NAME: _____DATE OF BIRTH: _____
(MM/DD/YY)

SOCIAL SECURITY NUMBER: _____

PATIENT SIGNATURE: _____ DATE: _____

FOR OFFICE USE ONLY

REQUESTED FROM: _____ DATE:_____

RELEASED TO: _____ DATE:_____

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Section 5 - Our Financial Policy

*** ACUPUNCTURE TREATMENTS.-** We do not accept insurance for Acupuncture treatments, unless we are participating providers of your insurance and your particular policy offers coverage for acupuncture. We will verify benefits with your insurance company for you. If that is not the case, payment is then due at time of service. We accept Visa, Master Card, Dinners Club, American Express, Discover card, or cash. The doctor is willing to make special financial arrangements to accommodate your financial circumstances, so that you can have the treatments. Please inquire about special arrangements to meet your needs. Since at our office services are provided by a medical doctor your initial medical consultation fee most likely will be covered by your insurance policy, at least to some extent. The actual acupuncture treatments will not be covered most of the time.

***REGENERATIVE MEDICINE/INTERVENTIONAL ORTHOPEDICS-** For these services we accept, Visa, Master Card, Dinners Club, American Express, Discover card, or cash.

***INSURANCE PATIENTS** – The percentage of coverage by your insurance company may be based on your insurance company's own reduced fee schedule for medical services, and may be less than actual charges, resulting in lower coverage for you. However if we are participating preferred providers for your insurance carrier, we are bound to accept their payment as full payment, excluding co-pays, deductible and co-insurance. This situation is outside of our control. Lower coverage and higher deductibles and co-pays are a direct result of the plan selected by you or your employer. Please be advised that we cannot waive co-payments or deductibles. If you have a secondary insurance policy, sometimes they will cover you deductible but not always. Finally, be aware that there are some procedures such as acupuncture and others that are not covered by some insurance because they arbitrarily considered them experimental.

***INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY** – We are not privy to this contract. If we participate with your insurance company, we will inform you and we will handle your claims according to our contract with that company. We file insurance claims as a courtesy to our patients. It is our policy not to become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered or non-covered services, or usual and customary allowable charges as per your contract. You are ultimately responsible for timely payment of your account.

***MEDICARE PATIENTS** – This office accepts traditional Medicare assignment. Medicare patients are fully responsible for the yearly deductible and 20% co-payment unless your secondary insurance picks that up. Most of the time they do. If not, federal law requires that we collect these amounts. If you have insurance in addition to Medicare, we also will submit this for payment. Be aware that Medicare does not cover Acupuncture, Regenerative medicine procedures such as Stem Cell therapy and some other procedure.

***NO INSURANCE – Other than for Acupuncture, or BMA Stem Cell Therapy, and Prolotherapy, as the sole form of payment, cash payment is accepted for no insurance patients.** We know that at times patients do not have insurance. If this is the case, the procedure and cost will be discussed prior to making the appointment and rendering the service. At this time a payment plan may be set up. **The doctor alone makes the final decision. More importantly, cash payment does not guarantee in no way shape or form a prescription of any kind and it does not guarantee that the doctor will continue to see you after your first consultation. Additionally the fee paid is not refundable.**

***MEDICAID** – This office accept traditional Medicaid assignment. **We are providers of Medicaid.**

***ASSIGNMENT OF INSURANCE BENEFITS** - In the event that you are entitled to any benefits of any type whatsoever arising out of a policy insuring you or any other party's liability to you, you hereby assign said benefits to Edward Dieguez, Jr., M.D. P.A. to be applied towards you bill.

***CHANGES OF INSURANCE COVERAGE** – It is your sole responsibility to notify our office of any changes in insurance coverage prior to having any service rendered to you. Failure to do so will automatically make you responsible of all charges. These charges will become due and payable immediately.

***I REALIZE ALL PAYMENTS ARE DUE WHEN SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE** – Failure to keep my account current may result in the doctor not being able to provide additional services. In the case of default on payment of my account, I agree to pay and additional 33% for collection costs, in addition to court costs, and reasonable attorney fees incurred while attempting to collect the account balance or any future outstanding account balances.

SIGNATURE OF RESPONSIBLE PARTY: _____

NAME OF RESPONSIBLE PARTY: _____

PATIENT NAME: _____ DATE: _____
(Please print)

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Section 6 – Signature on File Document

PATIENT: _____
(Please print)

HIC#: (Medicare Number) _____

I request that payment of authorized Medicare or other insurance benefits be made on my behalf to Edward Dieguez, Jr., M.D. for services rendered. I authorize any holder of medical information about me to release to Medicare or other insurance and it's agents any information needed to determine benefits for related services.

SIGNATURE: _____ ___ DATE:_____

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Section 7 - Prescription Refill Policy

Due to the nature of a medical practice, there may be, on a daily basis, a high volume of requests for refills. Each request requires a comprehensive chart review by a physician, and review of the Florida Prescription Drug Monitoring Program (PDMP) database as indicated. Therefore each patient is asked to adhere to the following protocol:

1. Ten (10)-business days (excluding weekends) prior to needing a refill, call our office at (904) 824-0955. If you have not been seen in three month, you will need to see the doctor before the prescription is issued or refilled.

2. For all prescriptions that can be called to your pharmacy, or prescribed electronically, please check with that pharmacy 2 business days after you have called our office. For all prescriptions that must be written, they will be issue only during a routine office visit. Call our office to make an appointment.

3. Refill messages received after 1:00 pm will be handled on the following business day.

With your cooperation, we will be able to better serve you and all of our patients. Thank you.

I fully understand, acknowledge and agree to abide by the above medication refill policy:

PATIENT'S NAME: _____
(Please print)

SIGNATURE: _____ DATE: _____

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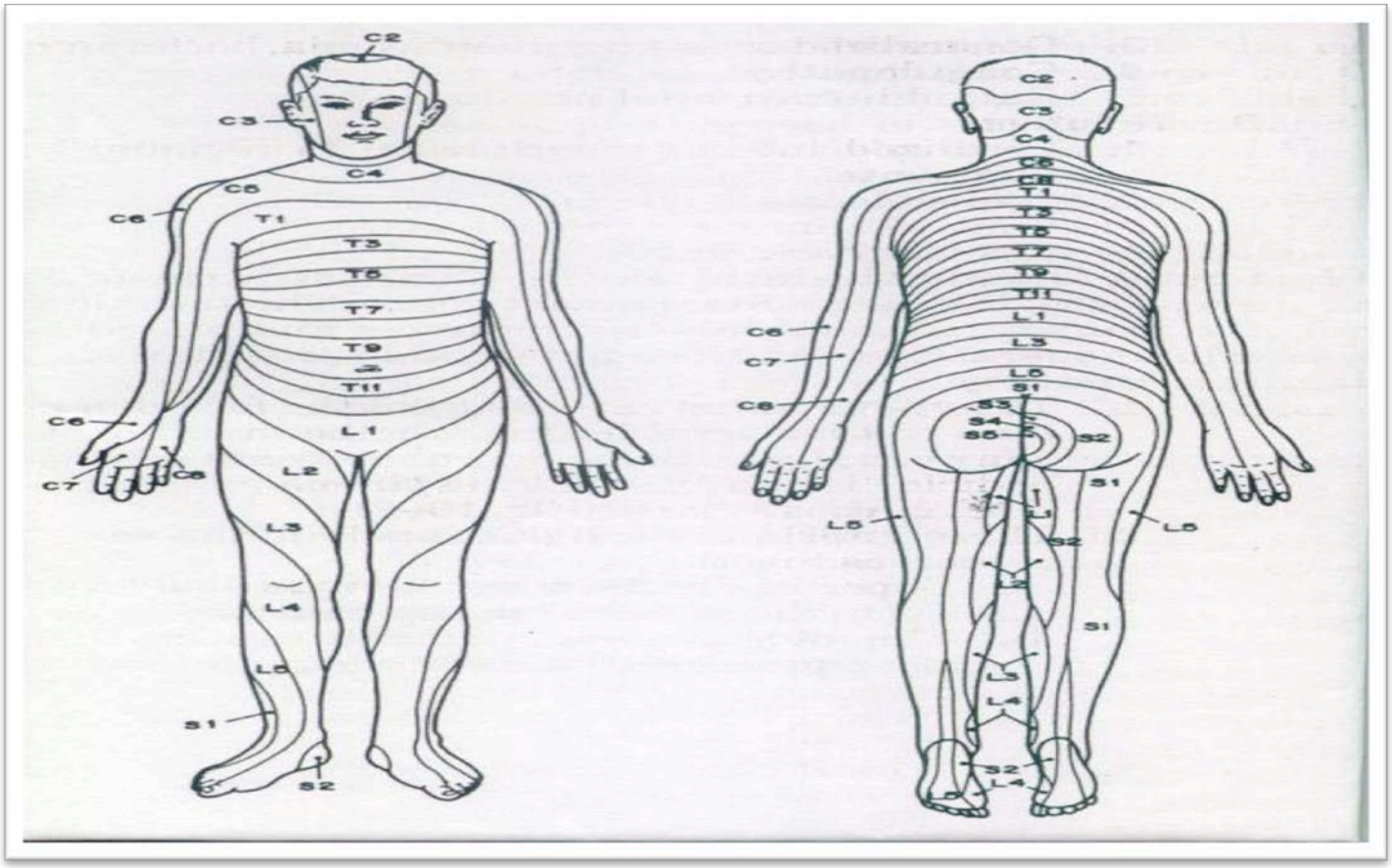
Section 8 - Pain Distribution Drawing

PATIENT: _____ DATE: _____
(Please print)

On the drawing below, please shade the area where you feel pain



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Section 9 - Authorization to Release Medical Information to Patient's Family or Friends

PATIENT NAME: _____
(Please print)

I hereby give my consent to **Edward Dieguez, Jr., M.D.** and his staff to discuss my medical condition—including, but not limited to, laboratory/radiology reports, procedures, treatment plans and medication regiment—with the individual (family or friend) listed below. I understand that this consent will remain in effect until or unless I provide further written notice.

NAME: _____

RELATIONSHIP: _____

ADDRESS: _____

_____

PHONE: _____

PATIENT' SIGNATURE: _____DATE: _____

WITNESS: _____ SIGNATURE: _____

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Section 10 – Acknowledgment

I am aware that all of the information I have provided on this Prospective Patient Information packet (Sections 1 – 10), including the foregoing authorizations for release of information about myself, will be utilized by Dr. Dieguez and staff to do a preliminary evaluation of my case and see if, at his sole discretion, he feels he can be of service to me or not. Additionally this information will expedite my appointment at the moment of arrival at the office avoiding long wait time.

I have provided to the best of my knowledge, truthful information in the foregoing questions and release forms. After a prompt review of the above information by Dr. Dieguez, I will be contacted by Dr. Dieguez office regarding an appointment.

PATIENT NAME: _____

PATIENT SIGNATURE: _____ DATE: _____