Welcome and thank you for choosing to become a patient of our practice. We will work diligently to ensure that you receive the best care available. We would like to take this opportunity to familiarize you with our office policies:

<u>Please bring the following items to your first visit:</u>

- Insurance card(s), picture ID and payment for co-pay or self-pay services
- **All medications you are currently taking in the bottles**
- The name, address, phone/fax number of your previous doctor(s) to obtain medical records
- <u>All NEW PATIENT paperwork, health history and required signatures</u>

<u>Reminders:</u>

- ***<u>It is your responsibility to review and understand your health insurance coverage and benefits.</u>*** This includes co-pays, the referral policy and approved outpatient facilities.
- If you are required to select a Primary Care Provider (PCP), please do so prior to your appointment or you may be asked to reschedule.
- There will be an annual administrative fee charged if you have an insurance plan with Alliant or Ambetter.
- For your convenience, we provide on-site lab services through VIM, LabCorp and Quest Diagnostics. If your insurance has specific requirements, it is your responsibility to notify us prior to your labs being drawn.
- New patients will only be allowed to reschedule or cancel their initial appointment twice, while providing no less than 24-hour notice. Failure to contact the office will result in dismissal from the practice and no further appointments will be scheduled.
- Payment for co-pays, non-covered or self-pay services are due in full at the time services are rendered, unless prior arrangements have been made with the billing office.
- To ensure patient care is not interrupted during the day, all calls for the Providers will be directed to the nurses.
- We provide same day and walk-in appointments for our established patients.
- In compliance with HIPAA laws, no information will be given to anyone, including family, without prior written consent.

Our goal is to provide you with the most efficient and up to date healthcare available. We are always open to suggestions. We look forward to seeing you!

Sincerely,
Dr. Mary Bell Vaughn and Vineville Internal Medicine Staff

www.vinevilleinternalmedicine.com

Be sure to like us on Facebook AND Instagram @vinevilleinternalmedicine

Your appointment is scheduled for ________/_______ /_______ at _______:______

3448 Vineville Avenue, MACON, GA 31204			
Bldg A - Blue	**Bldg B - Green**	**Bldg C - Purple**	**Acute Care Clinic-Bldg D - Yellow**
( ) Daryl Remick, MD	( ) Briana Birdsong, MD	( ) Mary Bell Vaughn, MD	( ) Jenna Franz, NP
( ) Erin Caves, NP	( ) Melissa Belflowers, NP	( ) Sarah Mitchum, NP	( ) Daryl Remick, MD
( ) Jarrett Mitchell, NP	( ) Shandora Hayman- Jones, NP	( ) Tammy Hughes, NP	
( ) Katie Aldridge, NP	( ) Shannon Ethridge, NP		
( ) Melissa Butts, NP			
1024 Keith Drive, PERRY, 31069			
( ) Kim Johnson, NP	( ) Gina Wiley, NP	( ) Tammy Hughes, NP	( ) H.Franklin Smisson, MD
147 James Street, GRAY, GA 31032			
( ) Jen Woodall, NP	( ) Jennifer Lee, NP	( ) Mary Bell Vaughn, MD	
506 Osigian Blvd, Warner Robins, GA 31088			
( ) Ashley Dykes, NP	( ) Krista Keen, NP	( ) Briana Birdsong, MD	

Thank you for choosing Vineville Internal Medicine (VIM) for your healthcare needs. We are committed to providing quality and affordable healthcare to you and your family. We strive to provide easy access to our Providers by offering an acute care clinic, multiple locations, telemedicine appointments, availability for same day visits and walk-ins for our established patients.

General Practice Policies

Telephone Calls: ****** If you* have a medical emergency, please call 911*****

- We have a great team of live operators to facilitate appointments and communications. But, due to heavy call volumes, some calls will be transferred to a voice mail box that is monitored continuously throughout the day. All calls received before 4pm will be returned within the same business day.
- To schedule an appointment, you may call us directly at 478-405-0045, Option #3, or use the Patient Portal Healow App.

Medication Refills:

- All prescription refills and renewals should be initiated through your pharmacy.
- We request 24-48 hours to process all prescription refill requests.
- Some refill requests may require an appointment for evaluation prior to being filled. You may call us directly at 478-405-0045, Option #1, or use the Patient Portal Healow App.

Missed Appointments:

- Our system is set to call and/or text reminders of your scheduled appointments.
- It is your responsibility to ensure your preferred method of contact and phone information is up to date in our system.
- Although we understand emergency situations may arise, we request 24-hour advance notice to cancel or reschedule your appointment. Canceling an appointment less than 24 hours (one business day) in advance will incur a "no show" fee of $25.00 for a regular office visit and $50.00 for a physical appointment.
- ***Three (3) late cancellations or "no show" appointments in one year may result in your dismissal from our practice***.

Minor Patients:

- Patients under the age of 18 will not be seen without a parent/guardian present or without a signed consent form. For all services rendered to minor patients, we will look to the adult accompanying the patient for payment.

Patient Portal Messaging:

- Your Provider may NOT feel that using the Healow messaging is appropriate and may request that you schedule an appointment.
- Complex messages that are going to require at least 20 minutes of your Providers' time could result in filing a claim to your insurance. (If you want to check on the specifics of this with your insurance, the CPT codes are 99421, 99422, and 99423)
    - Examples of these may include:
        - A new issue or symptom requiring medical assessment, medical decision-making or referral
        - Medication management, including dose adjustments, changes that you make to your pharmacy, emergency refills and short-term (30 days or less) refills when you are due for a follow-up visit
        - Chronic disease check-in management
        - Flare-up or change in chronic conditions

Dismissal:

- Repeated failure to keep your scheduled appointments, failure to comply with practice policies, or having an unpaid balance after the 3rd billing statement without making payment arrangements may result in dismissal from the practice.
- You will be notified by regular and/or certified mail that you have 30 days to seek alternative care. During that 30-day period, your Provider will only be able to provide treatment on an emergent basis.

Financial Policies

Patient Information:

- We require a valid government issued ID and a valid insurance card (if insured) at **EVERY** appointment.
- To ensure proper communication, we depend on you to provide our office with your correct address, phone number and any changes to your emergency contact information.

Insurance:

- It is your responsibility to ensure that the insurance information provided is current and accurate.
- Prior to your appointment, you must confirm with your insurance that Vineville Internal Medicine is in your covered network and, if required, that your selected Primary Care Provider (PCP) has been updated to a VIM Provider.
- Many insurance plans require the use of specific labs, radiology facilities, pharmacies, etc. It is your responsibility to verify your coverage benefits prior to your appointment.
- If additional information is requested by VIM or your insurance company, failure to respond will result in the charges being billed directly to you as patient responsibility.
- If you have an insurance plan that we do NOT accept, you will be considered a self-pay patient and payment is due in full at the time services are rendered.
- As part of our ongoing effort to manage the increase in administrative processes, we charge a **$100.00 annual administrative fee** to patients that have Ambetter or Alliant insurance plans.

Co-payments, Co-Insurance and Deductibles:

- Payment of co-pays, co-insurance and deductibles are part of your contract with your insurance company and are required per our agreement to accept your plan. Please help us in upholding the terms of these contracts by paying your co-payment at each appointment.

Non-covered services:

- You will be advised in advance if we believe the service requested (or deemed necessary by your Provider) may not be covered by your insurance. We will do our best to provide an estimate of the anticipated charges.
- Services that are never covered or services that exceed your limits of coverage will be billed directly to you.
- Cosmetic and non-medically necessary services are not filed with your insurance and payment is due in full at the time services are rendered.

Self-Pay Patients:

- For all services rendered to patients without insurance or proper proof of insurance, a self-pay discount will be applied to your account.
- Payment is due in full at the time services are rendered unless previous arrangements have been made with the billing office.

Credit Balances:

- In the event that a credit balance is created for any VIM date of service, we will verify that there are no outstanding balances on any other date of service and no future appointments are scheduled before initiating a refund.
- Because of the administrative expense of processing a refund, any credit balance of $20.00 or less will remain on the account for use at a future appointment.

Collections:

- If monthly payments are not received regularly, your account will move into our collection process. We are willing to work with you on your account balance, but communication with our billing office is essential. If you have questions regarding your billing statement or wish to set up payment arrangements, please contact our billing office by calling 478-405-0045, dialing ext. 888; or by selecting option #2.
- In the event your account balance is referred to a collection agency, your account will be made inactive and you will be dismissed from Vineville Internal Medicine.

Administrative Fees:

Biometric Forms	$20.00	Disability Forms:	$75.00
Life Insurance Forms	$20.00	Medical Records Requests:	$25.00
Physician Statements	$20.00	Parking/Handicap Permits:	$10.00
Other Miscellaneous	$20.00	FMLA Paperwork:	$75.00 (3 or more days); $100.00 (2 or less days)

I have read and understand the practice policies as stated above:

______________________________ ______________________________

Patient's Printed Name Signature of Patient or Legal Guardian

______________________________ ______________________________

Relationship to Patient (if other than self) Date

General Patient Information

Name (Last, First): ____ Gender: Male or Female

Preferred Name: ______________ Date of Birth: _______________________ SSN: ____________________________

Address: ____

City: ____ State: __________ ZIP: _______________

Communication

I authorize Vineville Internal Medicine to leave medical information pertaining to my care by the following methods and I will assume responsibility to notify them whenever this information changes:

Home Phone: ________________________________ Mobile Phone: _____________________________________
May we leave a voice msg at this number? YES or NO May we leave a voice/text msg at this number? YES or NO

Email: ____

**Emergency Contact Name: ______________________________________ Relation: _________________________

**Emergency Contact Phone: Home: ____________________________ Mobile #: ____________________________
**May we discuss medical information with this contact? YES or NO

Demographic Info

(Check as applicable)

Ethnicity: ____ Asian ____ African American ____ Caucasian ____ Hispanic _____ Other: ___________________
Language: ____ English ____ Spanish _____ Other: ______________________________
Marital Status: _____ Single _____ Married _____ Divorced _____Widowed
Employment Status: _____ Employed _____ Unemployed _____ Retired _____Disabled

Employer's Name: ____ Phone #: _______________________

Insurance

Please present your insurance cards along with a photo ID at the front desk so we can properly file your insurance.

Primary Insurance: _______________________________Policy #: _______________________Group #: ___________

Name of Insured: ____ DOB: ______________________

Secondary Insurance: _____________________________ Policy #: ____________________Group #: ______________

Name of Insured: ____DOB: _______________________

Health Information Disclosure (HID):

List anyone that may discuss health information on your behalf.

1. Name: ____ Relation: _________________________

Home Phone #: ________________________________ Mobile Phone #: ____________________________________

2. Name: ____ Relation: _________________________

Home Phone #: ________________________________ Mobile Phone #: ____________________________________

***I attest that all the above information is true and accurate to the best of my knowledge.**

Patient Name: ____ Date __________________________
(Please Print)

Signature: ____ **Date:** _________________________

PATIENT PORTAL CONSENT:

Vineville Internal Medicine complies with the Hitech Act of 2009 by communicating with our patients via patient portal. The patient portal is a secure, convenient and easy way to access your health information and communicate with your Provider.

- I ***DO*** want access to the Patient Portal. **(Enter email here: ____)**
  Upon registering for the Patient Portal, I will begin receiving electronic billing statements. **(Initial here: ___)**
- I ***DO NOT*** want access to the Patient Portal. **(Initial here: ___)**

ELECTRONIC PAPERLESS BILLING CONSENT *(If not using the Patient Portal):*

I authorize Vineville Internal Medicine to deliver my patient billing statements electronically via text message and/or email. This means that billing statements will no longer be submitted to my home by the postal service. This authorization will remain in effect until I provide written notice of termination to Vineville Internal Medicine.

Please Select: YES or NO (Initial here ______)

HIPAA Notice of Privacy Practices: Your Information. Your Rights. Our Responsibilities.

(Detailed policy available upon request)

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental healthcare
- Market our services and sell your information
- Raise funds

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Patient Name ____ Date _________________
(Please Print)

Patient Signature ____ Date _________________

Telemedicine Consent Form

- The purpose of the "Telemedicine Consent Form" is to obtain my consent to participate in telemedicine appointments. Signing this consent does not restrict my ability to participate in on-site office appointments with my Provider. This consent is to provide notification of the telemedicine service that is provided by Vineville Internal Medicine and use of this service is completely voluntary.

- Video conferencing will be used to affect such a consultation and will not be the same as a direct patient/healthcare Provider visit since I will not be in the same room as my healthcare Provider. The medical information related to history, records and tests will be discussed during my telemedicine appointment with video and audio. The telemedicine consultation will not be recorded and stored.

- I accept that I need access to a PC, laptop, or mobile device and an adequate internet connection to have an efficient telemedicine appointment. I accept that the session may be conducted via regular voice communication if the technical requirements, such as internet speed, cannot be met.

- I understand there are potential risks to technology, including interruptions, unauthorized access, and technical difficulties. I understand that my healthcare Provider or I can discontinue the telemedicine appointment if it is felt that the videoconferencing connections are not adequate for the situation.

- I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. I understand that I will be informed of the presence of other staff members that may be present during my consultation and that these staff members are required to maintain the confidentiality of the information obtained. I understand that I have the right to request the following: (1) omit specific details of my medical history; (2) ask non-medical personnel to leave; (3) terminate the consultation at any time.

- In choosing to participate in telemedicine appointments, I understand that some parts of the exam involving physical tests may be required to be done on-site at a physical location in the direction of my Provider. If I am receiving a schedule 2 drug, my Provider will do their best to e-prescribe this to my pharmacy. If this is unsuccessful, I will have to pick the prescription up from the office.

- I understand that the visit will be filed with my insurance company and any non-paid services are patient responsibility. Uninsured patients will need to contact the office for pricing and payment. I understand that 24-hour notice is required for appointment cancellation, or I will be charged a $25.00 no show fee. All pre-paid fees are non-refundable.

Patient Name: ____ Date of Birth: _________________________

Email: ____ Phone #: ______________________________

By signing this form, I certify:
I understand that all laws that are protecting my privacy of medical history or information are applied to telemedicine practices.
I have read or had this form read to me and/or had this form explained to me.
I fully understand its contents including the risks and benefits of the process, and I have been given the opportunity to ask questions and have received answers to my satisfaction.
I am responsible for any fees my insurance does not cover.

Patient Signature: ____ **Date:** __________________________________

The next generation of patient information

Permission to Create a *Health Exchange record* and Share My Medical Information with my Healthcare Providers

We are taking part in an exciting program to improve your healthcare and make office visits easier and more convenient. To do this, all your doctors participating in the Central Georgia Health Network (CGHN) would like your permission to share your Health Information (as defined below) through the *Central Georgia Health Exchange* electronic medical record program *(Health Exchange)*. This will authorize your CGHN-participating doctors to disclose your Health Information so that it can be shared electronically with other providers of healthcare to you.

I acknowledge that I have read the information set forth below and understand the permission I am giving in this document, and have had the opportunity to have my questions answered about the *Health Exchange and this* permission form.

☐ **Yes**, I **AGREE** to participate in the Central Georgia Health Exchange electronic medical record

☐ **No**, I do not wish to participate in the Central Georgia Health Exchange electronic medical record at this time

________________________	__/__/__	________________________	__/__/__
Printed Name of Patient/Representative	**DOB**	**Signature**	**Date**

AUTHORITY OF REPRESENTATIVE: POA

I, ______________________________ *do hereby state that I am authorized to sign this permission on behalf of the patient on the following basis:* *Relationship to Patient:*___________________________________

[A signed copy of this permission will be provided to the patient/representative]

This authorization will allow your CGHN-participating doctors to disclose you're demographic. Insurance. And medical information so that it can be shared with other providers of healthcare to you {including doctors, nurses. and other health professionals. as well as hospitals and other healthcare facilities) and CGHN, through the *Health Exchange* electronic medical record system. Only authorized healthcare providers and their contractors. And others whose job it is to maintain. secure, monitor and evaluate the operation of the information system and quality of care, would be able to access your information. The *Health Exchange* v II allow your providers access to your health information more quickly and accurately than with paper charts.

By signing this authorization, I authorize all of my doctors who participate in CGHN to use and disclose my Health Information and to make such Health Information available through the *Health Exchange* to other healthcare providers who need access to my Health Information for the purposes described in this document. The Health Information may include, but is not limited to the following: Information contained in medical records; physicians' records; surgeons' records; x-rays, CAT scans, MRI films, photographs, or other radiological, nuclear medicine or radiation therapy films; pathology materials, slides or tissues; laboratory reports; genetic testing results; discharge summaries; progress notes; consultations; prescriptions; records of child abuse, spousal abuse, drug abuse and alcohol abuse; HIV/AIDS and sexually transmitted diseases diagnosis or treatment; physicals and histories; nurses' notes; patient intake forms; correspondence; social workers' records; insurance records; consents for treatment; and any other documents concerning any treatment, examination, periods of hospitalization. Confinement, diagnosis or other information concerning my physical or mental condition. Information disclosed pursuant to this permission may no longer be protected by federal health information privacy laws and may be subject to re-disclosure. However, the *Health Exchange* system incorporates access controls. Encryption technology and other security features designed to protect the privacy and security of your Health information. In addition. Access to the *Health Exchange* will be limited to only those users who have agreed to use the *Health Exchange* consistent with your permission. Information shared through the *Health Exchange* will be used and disclosed for the following purposes and disclosures: clinical care; obtaining reimbursement for health care services; for administrative functions related to the provision of and payment for care; quality monitoring and improvement; and administrative management of the *Health Exchange* and CGHN.

You can learn more about the *Central* Georgia *Health Exchange* by reading the information booklet, "A Guide to the Central Georgia Health Exchange" that is available at the CGHE website {https://www.CGHE.net) or on request from your healthcare provider s office.

I understand that I may withdraw this permission by giving written notice to Administrator. Central Georgia Health Exchange, 111 Perimeter Parkway Macon. GA 31210. Any withdrawal of permission will be effective except to the extent action already has been taken in reliance on this permission. This permission will expire automatically if the *Central Georgia Health Exchange* program is discontinued.

I understand that my eligibility for treatment or any healthcare benefits cannot be conditioned on whether I sign this permission. However, to the extent I have refused permission, I understand that my Health Information will not be available to my other healthcare providers {including, but not limited to, participating Emergency Rooms, Urgent Care Centers, Hospitals, Surgery Centers, and Doctors' Offices) Il1roughthe *Central Georgia Health Exchange.*

Dr. Mary Bell Vaughn

Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/facility listed below.

Patient Name: ____ DOB: _________________________

Records being requested from:
Dr. ___________________________ Phone Number: ___________________ Fax Number: _____________________

Dr. ___________________________ Phone Number: ___________________ Fax Number: _____________________

Dr. ___________________________ Phone Number: ___________________ Fax Number: _____________________

Dr. ___________________________ Phone Number: ___________________ Fax Number: _____________________

The information you may release subject to this signed release form is as follows:
(**X**) Complete Records (**<u>last 2 years</u>**)
( ) Progress Notes
( ) H&P
( ) Other (Please specify below)
( ) Lab Reports
( ) Radiology Report
( ) Rx Records
( ) Pathology Reports
( ) Immunization Records
( ) Hospital Reports

____

____

____

(ONLY if this applies to you): <u>HIV/AIDS</u>: I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical records. If this applies, initial and date this form. Initial: _____ Date: _______________

Release my protected health information to the following physician/facility:
Dr. Mary Bell Vaughn
Vineville Internal Medicine
3448 Vineville Ave
Macon, Ga 31204

Phone: 478-405-0045
Fax: 478-405-0054

Patient Name (Please Print) ____ Date: _______________________

Signature: ____ Date: _______________________

PATIENT HEALTH QUESTIONNAIRE

Name: ____ Date: _____________________

INSTRUCTIONS: This questionnaire will help your Provider better understand problems that you may have. Your Provider may ask you more questions about some of these terms. Please make sure to check a box for every item.

During the **PAST MONTH**, have you **OFTEN** been bothered by:
(Please check YES or NO)

	YES	NO
1. Back Pain?		
2. Pain in your arms, legs or joints?		
3. Menstrual pain/problems?		
4. Irregular periods?		
5. Pain or problems during sexual intercourse?		
6. Headaches?		
7. Chest pain?		
8. Dizziness?		
9. Fainting spells?		
10. Feeling your heart pound or race?		
11. Shortness of breath?		
12. Constipation, loose bowels or diarrhea?		
13. Need to get up at night to urinate regularly?		
14. Nausea, gas or indigestion?		
15. Feeling tired or low energy?		
16. Trouble sleeping?		
17. The thought that you have a serious, undiagnosed disease?		
18. Your eating being out of control?		
19. Little interest or pleasure in doing things?		
20. Feeling down, depressed, or hopeless?		
21. Nervous, or feeling anxious or on edge?		
22. Worrying about a lot of different things?		
23. Have you had an anxiety attack, unreasonable feeling of fear or panic?		
24. Thoughts you should cut down on your drinking alcohol?		
25. Anyone complaining about your alcohol use?		
26. Feeling of guilt or anger about your drinking?		

Overall, would you say your health is:
(Please Check One)

☐ Excellent

☐ Very Good

☐ Good

☐ Fair

☐ Poor

Medications/Dosages:

____

____

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CHECK PAST ILLNESSES

	AGE		AGE		AGE
ADD/ADHD	___	Diabetes	___	Rheumatologic Disease	___
Anemia	___	Depression	___	Seizures	___
Anxiety	___	Emphysema	___	Stroke	___
Arthritis	___	Erectile Dysfunction	___	Substance Abuse	___
Asthma/Allergies	___	Fibromyalgia	___	Other (Please specify below):	
Atrial Fibrillation	___	Gallstones	___	___________________________________	
Blood Clot	___	Gout	___	___________________________________	
High Blood Pressure	___	Heart Attack	___	___________________________________	
Cancer	___	Heartburn/Reflux	___	___________________________________	
High Cholesterol	___	Kidney Disease	___	___________________________________	
COPD	___	Liver Disease	___	___________________________________	

Number of pregnancies? ______ Number of live births? ______ Number of living children? ______ Pregnancy complications? _____

Serious injuries, illnesses or hospitalizations (Year): ____

____

Operations: (Year) ____

Last Pap: ______________ Abnormal Pap tests: Y N Last Mammogram: _______________ Colonoscopy: _________________

Immunizations: (Date) Tetanus _______HPV _______ Pneumonia _______ Shingles _______ Hepatitis B _______ Meningitis _______

Allergies (medications, pollens, foods, ets): ____

How often do you exercise? _____________ How long do you exercise? _________ What are your hobbies?____________________

How is your sleep? __________________________ How is your diet? ____

Alcohol (avg # of drinks per day): _______ Recreational drug use (include type and age started): ______________________________

Have you ever smoked? Y N How long? _________ How much? _________ Tried to stop smoking? Y N Quit Date: _________

Birthplace: _____________________ Places you've lived and traveled: ____

____

Special problems related to home or work conditions: ____

Check if anyone in your family has ever had the following:

	Relationship		Relationship		Relationship
___ Diabetes	__________	___ Stroke	__________	___ Gout	__________
___ High Blood Pressure	__________	___ Migraine Headaches	__________	___ Asthma	__________
___ Anemia	__________	___Obesity	__________	___ Arthritis	__________
___ Heart Disease	__________	___ Thyroid Disease	__________	___ Mental Illness	__________
___ Cancer (type)	__________	___ Elevated Cholesterol	__________	___ Allergies	__________
___ Bleeding Disorder	__________	___ Kidney Disorder	__________	___ Other	__________

	IF LIVING		IF DECEASED	
	Age	State of Health	Age	Cause
Mother	____	_______________	____	________________
Father	____	_______________	____	________________
Brother	____	_______________	____	________________

	IF LIVING		IF DECEASED	
	Age	State of Health	Age	Cause
Sister	_____	______________	_____	________________
Husband/Wife	_____	______________	_____	________________
Children	_____	______________	_____	________________

If you need more space, please use back side