Welcome to The Sandra and Malcolm Berman Brain & Spine Institute

☞ You have an appointment with
☐ Dr. Gurdeep S. Ahluwalia ☐ Dr. Adrian Goldszmidt
on ____________, ______________, 20____ at ________ __ am

day of the week month and day

☞ You are expected to arrive at your registration time ________ __ am

☞ You will receive an automated reminder call 48 hours prior to your appointment.

☞ We will call you the day before your appointment to remind you.

Things You Must Know or Do

1. Read the pages of this packet for important instructions.
2. Complete and sign the forms on pages 6–14 of this packet before your visit and bring them with you when you come (do not mail them).
3. If you do not arrive in sufficient time to allow for registration or if you do not bring a required referral, your appointment may be rescheduled.
4. If your insurance company requires you to obtain a referral, it is your responsibility to do so.
5. To print more copies of this packet, go to www.lifebridgehealth.org/NeurologyAppointments.

Things You Must Bring

1. Insurance card
2. Co-pay, if necessary
3. Photo ID
4. Referral, if necessary, and/or authorization from requesting physician
5. A list of current medications (page 14 of this packet) or bring your medication bottles

If you have any questions, please contact us at
☞ 410-701-4437 or bsiphysicians@lifebridgehealth.org

We look forward to caring for you.
Gurdeep S. Ahluwalia, MD, received a medical degree from the Howard University College of Medicine. His postgraduate work includes a one-year internal medicine internship, followed by a four-year neurology residency at the Howard University Hospital.

Dr. Ahluwalia received additional fellowship training in clinical neurophysiology at Hahnemann University Hospital (Drexel University). He also holds a master’s degree in genetics and human genetics from Howard University. Dr. Ahluwalia is a frequent lecturer and instructor on stroke, seizures, and other neurologic disorders. His special interests include the use of electromyography and electroencephalography techniques to treat neurophysiologic, neuromuscular, and sleep disorders. As a faculty member of The Sandra and Malcolm Berman Brain & Spine Institute, Dr. Ahluwalia provides services in clinical neurophysiology and consults for general neurology at Northwest Hospital.

Adrian Goldszmidt, MD, is chief of the department of neurology at The Sandra and Malcolm Berman Brain & Spine Institute, chief of the Division of Neurology at Northwest Hospital, and director of the Primary Stroke Center at Sinai Hospital. His main areas of expertise are headaches and stroke. As a general neurologist, Dr. Goldszmidt consults with patients who have all manner of disorders of the brain and spine—from movement disorders to traumatic brain injury, from epilepsy to hydrocephalus. In fact, he will often see patients after they have been to several doctors who have been unable to help them. And after careful questioning and testing, Dr. Goldszmidt finds a way to get these patients on the road to recovery.

After completing medical school at Harvard University in Cambridge, Massachusetts, Dr. Goldszmidt trained in neurology at Harvard's Longwood program in Boston and completed a stroke fellowship at New England Medical Center and Spaulding Hospital, also in Boston. Certified by the American Board of Psychiatry and Neurology, Dr. Goldszmidt is member of the American Stroke Association, the Stroke Council, and the American Academy of Neurology.

Under Dr. Goldszmidt’s leadership, the stroke center at Sinai Hospital was certified as a Primary Stroke Center by the American Heart Association/American Stroke Association and by the Maryland Institute for Emergency Medical Services Systems. It has also earned numerous awards for its consistent delivery of high-quality care to patients with stroke.
Directions to the Neurology Suite at Northwest Hospital Professional Center

5415 Old Court Road ● Street Level ● Suite S04 ● Randallstown MD 21133 ● 410-701-4437

From I-695:
Take the Beltway to Exit 18B (Randallstown), Liberty Road.
Proceed 2 miles to Old Court Road.
Turn left onto Old Court Road and go one block to Carlson Lane.
Turn left on Carlson Lane.
Turn right into Visitor Parking.
The professional building will be immediately in front of you.
The neurology suite is on the street level (S) in room S04, across the hall from Dental Care of Baltimore.

From I-795:
Follow signs to Baltimore. Take Exit 1B to I-695 West (Glen Burnie).
Take the Beltway to Exit 18B (Randallstown), Liberty Road
Proceed 2 miles to Old Court Road.
Turn left onto Old Court and go one block to Carlson Lane.
Turn left on Carlson Lane.
Turn right into Visitor Parking.
The professional building will be immediately in front of you.
The neurology suite is on the street level (S) in room S04, across the hall from Dental Care of Baltimore.

From Southern Carroll County:
Take Liberty Road (Route 26) toward Baltimore.
Turn right onto Old Court Road and go one block to Carlson Lane.
Turn left on Carlson Lane.
Turn right into Visitor Parking.
The professional building will be immediately in front of you.
The neurology suite is on the street level (S) in room S04, across the hall from Dental Care of Baltimore.
Important Information

You will be seen at
Northwest Hospital Professional Center
5415 Old Court Road, Street Level, Suite S04
Randallstown MD 21133

Visitor parking is located on the parking lot surrounding the professional center building.

Please help us to be respectful to all of our patients and to our physicians and arrive at the registration time that appears on the front page of this packet.
If you do not arrive on time, we may reschedule your appointment.
If you have any questions, please call 410-701-4437.

✎ Please bring your insurance card and photo ID with you to every visit.

✎ If your insurance requires a referral, please ensure that it is valid and that we have a copy of it prior to your visit. **It is your responsibility to obtain the referral and to follow through to ensure that we have it.** If you do not have your referral at the time of your scheduled visit, **we may reschedule your appointment, or you will be responsible for your bill.** Please inform us before your appointment of any changes in your insurance coverage.

**SCHEDULING, CANCELLATIONS, and NO-SHOWS**
All follow-up appointments should be scheduled by calling **410-701-4437.** Please book your follow-up appointments as soon as possible. We will call you the day before to your appointment to remind you. On page 9 of this packet, please let us know the best way to reach you (home, work, cell, and pager) for confirmation.

✎ If for any reason you cannot make your appointment, **call 410-701-4437** to cancel at least 72 hours prior to your appointment.

✎ If you do not arrive for your scheduled appointment and you have not canceled at least 24 hours in advance, **you will be charged a $25 no-show fee.**

**NO-SHOW POLICY**
After patients miss their first and second appointments without letting us know, we write to remind them that our policy is that they must tell us at least 24 hours in advance if they are going to miss their appointments and that if they do not call at least 24 hours in advance, they will be charged a $25 no-show fee.

If they miss a third appointment without letting us know, we write to advise them that we will no longer provide for their care, that we will be dismissing them from our practice, and that we will renew a needed prescription for only 30-day supply, so that they have time to find a new provider.
NECESSARY MEDICAL INFORMATION FOR YOUR VISIT
Please have available for the physician the name, office address, and phone number of your referring physician and/or primary care provider so that we can communicate with him/her. Please bring a written list of all medications that you currently take, including dose and frequency, or bring the medication bottles—this is important for new and follow-up patients.
If you have had any relevant testing (MRIs EEG, bloodwork, consultations/reports from other providers), please ensure that you bring those reports and/or films with you. NOTE: We are not able to copy reports that you bring with you. Please come prepared with copies that you will leave with us.

Do not assume that your primary care physician will send this information.

MESSAGES/PHONE CALLS
We attempt to return all phone calls within 24 hours. Sometimes, your call will be returned by another physician or by our physician assistant. If you are comfortable with e-mail, we would be happy to communicate with you by email. You can write to our physicians at bsiphysicians@lifebridgehealth.org.

PRESCRIPTION REFILLS
For prescriptions refills, your pharmacy must fax a refill authorization request to us at 410-701-4421. If we have no questions, we will refill your prescription. All refill requests will be completed within 2 business days of receipt, and you should follow-up with your pharmacy to check on the refill.

Please do not wait until the last minute to contact your pharmacy to request a refill.
If your pharmacy advises you of problems with the refill, call 410-701-4437. If your call is answered by the messaging system, please leave a complete message. We will resolve any issues within 2 business days.

IF YOU EXPERIENCE PROBLEMS WITH YOUR MEDICATION AND NEED EMERGENCY CARE, CALL 911.
If you experience problems with your medication but do not need emergency care, call 410-701-4437 and leave a complete message.

DO NOT call this phone line for automatic refill requests.

BILLING QUESTIONS
Before your visit, we check to determine if your insurance is active and to obtain any authorizations that are required. However, it is your responsibility to obtain any referral that may be required by your insurance company and to determine your financial responsibility for your visit, including any amounts that will be charged against your deductible or co-insurance. If you require billing codes to determine your out-of-pocket expenses, we will be happy to provide them. We must receive the request for this information a minimum of 5 business days prior to your appointment.
Following your visit, you may receive two bills, one for physician services and one for hospital services.

For billing questions about your doctor’s bills, please call 410-469-4369. For questions about bills from Sinai Hospital, call 410-601-1094 (800-788-6995 out of Baltimore area). For questions about bills from Northwest Hospital, call 410-521-5959 (877-617-1803 out of Baltimore area).

We know that the payment and the insurance process related to your visit may seem confusing. Please do not hesitate to ask any staff member for clarification. We are here to ensure that your visit is productive, positive, and comforting.

Our staff is committed to providing quality care and customer service to all of our patients. Your safety and privacy are important to us, and we will do our utmost to safeguard them. If during your visit you have any questions or concerns, please do not hesitate to let us know. If at any time you are not satisfied with the handling or resolution of your concern, you may contact Guest Relations at 410-601-8778.

Thank you for your attention to our policies. We look forward to seeing you and will do our best to provide you with excellent care.
NAME: ____________________________    DATE: ____________________________

SOCIAL SECURITY #: ____________________________    DOB: ____________________________    SEX: ______

ADDRESS: ________________________________________________________________

CITY, STATE, ZIP ___________________________________________________________

HOME TELEPHONE: ____________________________ WORK TELEPHONE: ____________________________

CELL PHONE: ____________________________ EMAIL ADDRESS: ____________________________

MARITAL STATUS: ___________ LANGUAGES: ___________ RELIGION: ___________

ADVANCE DIRECTIVES
DO YOU HAVE A LIVING WILL OR ADVANCE DIRECTIVE?  ☐ YES  ☐ NO

HAVE YOU NAMED A PERSON TO MAKE MEDICAL DECISIONS FOR YOU
IF YOU ARE UNABLE TO MAKE THOSE DECISIONS FOR YOURSELF?  ☐ YES  ☐ NO

IF SO, WHO IS THAT PERSON? ________________________________________________________

INSURANCE HOLDER INFORMATION and/or EMPLOYMENT INFORMATION:

NAME OF INSURED IF OTHER THAN PATIENT: __________________________________________

SSN: __________________________________

RELATIONSHIP: ____________________________    DOB: ____________________________

EMPLOYER: ____________________________ OCCUPATION: ____________________________

ADDRESS: ____________________________ PHONE: ____________________________

CITY, STATE, ZIP: ____________________________

NAME OF INSURANCE: ____________________________

EFFECTIVE DATE: ____________________________ RETIREMENT DATE: ____________________________

INSURANCE ID NUMBER: ____________________________

PLEASE COMPLETE OTHER SIDE>>>>>>

The information furnished above will be used ONLY for billing and accounting purposes.
Neurology New Patient Registration Sheet–page 2
Please bring these documents on the day of your appointment.

PATIENT NAME ____________________________________________

EMERGENCY CONTACT
NAME: ___________________________ RELATIONSHIP: ______________________
WORK NUMBER: ___________________ HOME NUMBER: ______________________

REFERRING PHYSICIAN
NAME: ___________________________ PHONE: ____________________________
FAX: ____________________________
ADDRESS: ____________________________________________________________
CITY, STATE, ZIP: _______________________________________________________

PRIMARY CARE PHYSICIAN
NAME: ___________________________ PHONE: ____________________________
FAX: ____________________________
ADDRESS: ____________________________________________________________
CITY, STATE, ZIP: _______________________________________________________

PHARMACY
NAME: ___________________________
PHONE: _________________________
FAX: ___________________________
Authorization and Assignment
of Insurance Benefits

Patient name

The undersigned patient, or authorized individual acting on behalf of the patient, understands and agrees to the following:

1. I authorize payment of medical benefits to the physician(s) rendering service(s).

2. I agree and acknowledge that my signature on this document authorizes my physician(s) to submit claims for benefits, services rendered, or services to be rendered without obtaining my signature on every claim submitted for me and/or my dependent(s). I will be bound by this signature as though the undersigned had personally signed the particular claim.

3. I will pay to the physician(s) any balance due for services rendered. I understand that if payment is not made on my behalf (by my insurer, legal representative, or workers compensation insurance), I will be responsible for any outstanding balance.

4. I understand that the Sinai Department of Neurology checked with my insurance company prior to this visit to determine whether my insurance is active and to obtain any required authorizations.

5. If I have received neurodiagnostic testing, I understand that following my visit, I will receive two bills—one for the doctor's services and one for the hospital's services.

6. I understand that it is my responsibility to obtain any referrals required by my insurance company and to determine my financial responsibility for all charges for this visit, including those from the doctor and from the hospital and any amounts that will be charged against my deductible or co-insurance.

☐ The reason for this visit is not the result of a motor vehicle accident and is not covered by my automobile insurance.

☐ The reason for this visit is the result of a motor vehicle accident, and the claim for services provided should be submitted to my insurance carrier:


☐ The reason for this visit is not the result of a Workers Compensation claim and, therefore, payment for this visit is not eligible for payment by Workers Compensation insurance.

☐ The reason for this visit is the result of a Workers Compensation claim, and the claim for services provided should be submitted to my Workers Compensation carrier:


I UNDERSTAND THAT IF I HAVE NOT PROVIDED CORRECT AND TRUTHFUL INFORMATION REGARDING THE REASON FOR THIS VISIT AND INSURANCE COVERAGE, I WILL BE RESPONSIBLE FOR ANY UNPAID CLAIMS.

______________ ________________ ________________
signature of patient, parent/guardian, guarantor date
Patient Authorization

The providers in the Department of Neurology are dedicated to preserving your privacy and personal health information. Our employees are trained in the proper handling of your medical and financial records. We are requesting this Patient Authorization in order to continue to provide the finest medical care possible. Thank you for your assistance.

I authorize the Department of Neurology to:

1. Call my home and/or work to remind me of upcoming appointments; in the event I am not there, leave a message on an answering machine.
2. Send reminder notices for upcoming appointments or when it is time to schedule an appointment.
3. Send me notices, clinical notes, and lab results via:  
   - text message
   - email
4. I would like to receive an email invitation that provides instructions on how to register for the Sinai Hospital Patient Portal.
   - yes
   - no

5. Call my home or work and leave a message to contact the office.

   My preferred method of contact for appointment reminders is
   - home phone
   - cell phone
   - text message on cell phone
   - email

6. Make and/or receive calls from pharmacies on my behalf, including prescriptions by FAX.
7. Update my personal demographic information either on the phone or in the office at the time of my appointment.
8. I give permission to discuss my personal health with the designated person(s) below:

<table>
<thead>
<tr>
<th>name</th>
<th>relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>name</td>
<td>relationship</td>
</tr>
</tbody>
</table>

I have read and agree to the above policies.

_____________________________  _________________________
patient signature              date
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

<table>
<thead>
<tr>
<th>Patient's Name</th>
<th>Patient's Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient's Street Address</td>
<td>Social Security Number</td>
</tr>
<tr>
<td>City, State, Zip Code</td>
<td>Phone Number</td>
</tr>
</tbody>
</table>

I, the undersigned, hereby authorize

- [ ] to release copies of medical records to:
- [ ] to obtain copies of medical records from:
- [ ] Verbal release only of medical information to:

<table>
<thead>
<tr>
<th>Name of Person or Agency</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>BSI @ NWH, Department of Neurology</td>
<td>410-701-4437</td>
</tr>
<tr>
<td>5415 Old Court Road, Suite S04, Randallstown MD 21133</td>
<td>410-701-4421</td>
</tr>
</tbody>
</table>

Address

City, State, Zip Code

Fax Number

The purpose or need for such disclosure is ___________________________.

Dates of Service: ___________________________.

_________________________ is authorized to release the following: (Please check information to be released) The medical records to be released may contain medical information pertaining to mental health services, drug and/or alcohol diagnosis and treatment, HIV/AIDS testing, HIV/AIDS results or HIV/AIDS information.

- [ ] Abstract (Summary, Op Report, Paths, Consults, H&P, lab work)
- [ ] Emergency Room Record
- [ ] Outpatient Surgery
- [ ] Discharge Summary
- [ ] Admission History and Physical
- [ ] Consultation Report
- [ ] HIV/AIDS Report
- [ ] Doctor's Office Notes
- [ ] Operative Report / Pathology Report
- [ ] Alcohol / Detox / Drug Abuse
- [ ] X-ray, EKG, EEG, Labs, Cardiopulmonary
- [ ] Physical Therapy / OT / Speech
- [ ] Nuclear Medicine
- [ ] Clinic
- [ ] Mental Health / Psychiatry
- [ ] Other ___________________________

Signature ___________________________ Date ___________________________

Witness ___________________________ Date ___________________________

Relationship to Patient ___________________________

This authorization will expire within 1 year unless otherwise indicated. The consent to disclose information may be revoked by me at any time in writing except to the extent that action has been taken in reliance thereon, as set forth in the LifeBridge Health Notice of Privacy Practices. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. Subsequent re-disclosure or recopying of this information is not authorized without specific consent of the patient or authorized representative as provided in the Annotated Code of the State of Maryland, Article 4-302 (d) *Photo Id may be requested at the time of release.*

MR7350-501-L (12/05)
Name: ____________________________ Age: ______

Birthdate __________________________
               mm/dd/year

Reason for Visit

____________________________________

____________________________________

Medical Problems

1. Diabetes    Yes  No     6. Head trauma/injury     Yes  No
2. Hypertension Yes  No     7. Headaches      No  No
3. Heart disease/attack Yes  No
4. Stroke       Yes  No
5. Arthritis    Yes  No
6. Head trauma/injury     Yes  No
7. Headaches      No  No
8. Surgical Issues/Operations: ______________________
9. Other: _______________________________________

Family History

Father: age ______  □ Deceased  Health problems: __________________________

Mother: age ______  □ Deceased  Health problems: __________________________

Brother(s): age ______  □ Deceased  Health problems: __________________________

Sister(s): age ______  □ Deceased  Health problems: __________________________

Social History

Tobacco □ No  □ Yes (amount)________________________ How many years? _______

Alcohol □ No (only social) □ Yes __________________________ How many years? _______

Marital Status: □ Married     □ Divorced    □ Single    □ Widowed    □ Other    # of children ______

Education: □ High School  □ College  □ Post-graduate □ Other

Occupation: Past: __________________________ Present: __________________________

Exercise: □ No  □ Yes How much? __________________________

Hobbies: ______________________________________

revised 6/16
PATIENT NAME __________________________________________________________

**Tests (Please bring copies of results and ORIGINAL FILMS).**

<table>
<thead>
<tr>
<th>Test</th>
<th>Date</th>
<th>Results</th>
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<tbody>
<tr>
<td>1. Brain MRI/MRA</td>
<td>__________</td>
<td>□ Normal</td>
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<tr>
<td>2. Spine MRI</td>
<td>__________</td>
<td>□ Normal</td>
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<tr>
<td>3. Head CT</td>
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<td>□ Normal</td>
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<td>4. EEG</td>
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<td>□ Normal</td>
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<tr>
<td>5. EMG/NCS</td>
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<td>□ Normal</td>
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<tr>
<td>6. Carotid Ultrasound</td>
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<td>□ Normal</td>
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<td>7. Other</td>
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Please add any additional information you think might be pertinent.

__________________________________________________________

__________________________________________________________

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**Symptoms you have experienced in the past few months.**

**General**

☐ Weight loss       ☐ Weight gain       ☐ Fatigue       ☐ Fever/chills
☐ Nausea           ☐ Vomiting           ☐ Sleep problems

**Neurologic**

☐ Headaches        ☐ Memory loss       ☐ Dizziness       ☐ Vertigo (sensation of room spinning)
☐ Difficulty walking ☐ Falls             ☐ Muscle pain     ☐ Weakness all over
☐ Tremor           ☐ Muscle spasms     ☐ Sensitivity to noise ☐ Difficulty with coordination
☐ Head injury      ☐ Flashing lights    ☐ Sensitivity to light ☐ Pain radiating into arms or legs
☐ Back pain        ☐ Neck pain         ☐ Seizures
☐ Numbness/tingling in ____________________________

**Ears/Nose/Mouth/Throat**

☐ Hearing loss     ☐ Ear pain          ☐ Ringing in ears ☐ Vertigo (sensation of room spinning)
☐ Swallowing difficulty ☐ Poor vision ☐ Hoarseness or change in voice

**Psychiatric**

☐ Nervousness      ☐ Anxiety          ☐ Panic attacks
☐ Hallucinations   ☐ Depression       ☐ Learning problems ☐ Difficulty with concentration
☐ Mood swings      ☐ Suicidal thoughts ☐ History of drug abuse ☐ History of alcohol abuse
PATIENT NAME ____________________________

**Cardiovascular**
- □ High blood pressure
- □ Heart murmur
- □ Heart failure
- □ Cough
- □ Shortness of breath
- □ Irregular heartbeat
- □ Syncope
- □ Angina/chest pressure
- □ Faintness/lightheadedness

**Other**
- □ Ulcer disease
- □ Abdominal pain
- □ Reflux disorder
- □ Sexual dysfunction
- □ Skin problems
- □ Excessive or decreased sweating
- □ Bleeding problems
- □ Kidney problems
- □ Bladder problems

**WOMEN ONLY**
- # pregnancies ______ # miscarriages ___
- Last menstrual period _____________________
- □ Yes □ No

**Birth control pills**
- □ Yes □ No

**Hormone replacement therapy**
- □ Yes □ No

**Menopause**
- □ Yes □ No

______________________________
patient’s signature

______________________________
physician’s signature
**PATIENT NAME ________________________________**

**Medications—Current**
*(Please include over-the-counter medications, e.g., aspirin, Aleve, Advil, herbs, and vitamins.)*

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<th>Dosage</th>
<th>Times per day</th>
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**Medications—Previous:** *(Medications used in the past for your current problem.)*

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<th>Name of Medication</th>
<th>Dosage</th>
<th>No.</th>
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<th>Dosage</th>
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**Medication Allergies:**

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________