MICHAEL A. CASTILLO, MD
Next Generation Treatment for Pair

NEW PATIENT REGISTRATION FORM

Date:

Email Address:

Preferred Provider:

Patient Information

Last Name: First Name: MI:

Date of Birth: Age: SSN:

Address:

City: State: Zip Code:

Please check primary phone Home Phone☐ Cell Phone☐ Work Phone☐

Martial Status: Single Married Divorced Widowed Other

Gender: ☐Male ☐Female

Race: Ethnicity Preferred Language:

Occupation: Employer:

Primary Insurance Information

☐*Check if same as patient*

Primary Insurance Name:

Name of Policy Holder: DOB: SSN:

Relationship to the patient: Employer:

Policy#: Group#:

Secondary Insurance Information (Only if Applicable)

Secondary Insurance Name:

Name of Policy Holder: DOB: SSN:

Relationship to the patient: Employer:

Policy#: Group#:

I hereby authorize the offices of Michael A. Castillo, MD, to release any medical information required during the course of examination and treatment to my insurance company, and I permit payment to the practice from my insurance for any benefits due for their services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes but is not limited to coinsurance, copayment, deductible, and non-covered services. I understand that I am responsible for all charges incurred regardless of the insurance status. I agree to pay for services incurred after the patient has been charged for the office visit, such as labs, medical supplies, etc. I agree to pay my bill in full for services rendered by Michael A. Castillo, MD and providers.

Patient Signature: Date:

Patient Name _____ **Chief Complaint** _____

Pain Description

What number on the pain scale (0-10) best describes your pain right now? _____

What number on the pain scale (0-10) best describes your worst pain? _____

What number on the pain scale (0-10) best describes your least pain? _____

Where is your worst area of pain located? _____

Does this pain radiate? If so, where? _____

Please list any additional areas of pain: _____

Onset of Symptoms

Approximately when did this pain begin? _____

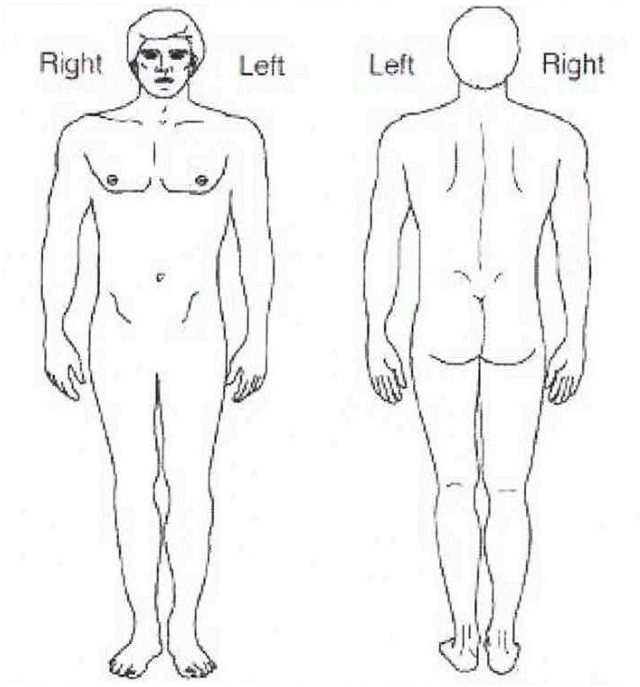
What caused your current pain episode? _____

How did your current pain episode begin? _____

☐ Gradual ☐ Suddenly

Use this diagram to indicate the location and type of your pain. Mark the drawing with the following letters that best describe your symptoms:

"N" = numbness
"S" = stabbing
"B" = burning
"P" = pins & needles
"A" = aching



Pain Description - Check all of the following that describe your pain:

☐ Aching	☐ Numbness	☐ Spasming	☐ Throbbing
☐ Cramping	☐ Shock-like	☐ Squeezing	☐ Tingling/Pins & Needles
☐ Dull	☐ Shooting	☐ Stabbing/Sharp	☐ Tiring/Exhausting
☐ Hot/Burning			

Pain Frequency

What word best describes the frequency of your pain? Constant Intermittent

When is your pain at its worst? ☐ Mornings ☐ During the Day ☐ Evenings ☐ Middle of the night

Patient Name _____ **DOB** _____

Mark all of the following activities that are adversely/negatively affected by your pain

- ☐ Enjoyment of Life
- ☐ General Activity
- ☐ Mood
- ☐ Normal Work
- ☐ Recreational Activities
- ☐ Relationship with people
- ☐ Sleep
- ☐ Walking
- ☐ Other: _____

Diagnostic Tests and Imaging

- ☐ MRI of the _____ Date: _____ Facility: _____
- ☐ X-ray of the _____ Date: _____ Facility: _____
- ☐ CT scan of the _____ Date: _____ Facility: _____
- ☐ EMG/NCV study of the _____ Date: _____ Facility: _____
- ☐ Ultrasound of the _____ Date: _____ Facility: _____
- ☐ Other diagnostic testing: _____

☐ **I Have Not Had Any Diagnostic Tests Performed for My Current Pain Complaints**

Pain Treatment History

Mark all of the following pain treatments you have undergone prior to today's visit:	Beneficial	
☐ Chiropractic	Yes	No
☐ Physical Therapy	Yes	No
☐ Psychological Therapy	Yes	No
☐ Discogram – (circle all levels that apply) Cervical / Thoracic / Lumbar	Yes	No
☐ Epidural Steroid Injection – (circle all levels that apply) Cervical / Thoracic / Lumbar	Yes	No
☐ Joint Injection – Joint(s) _____	Yes	No
☐ Medial Branch Blocks or Facet Injections (circle all levels that apply) Cervical/Thoracic/Lumbar		
☐ Nerve Blocks – Area/Nerve(s) _____	Yes	No
☐ Radiofrequency Ablation – (circle all levels that apply) Cervical / Thoracic / Lumbar	Yes	No
☐ Spinal Column Stimulator – (circle one) Trial Only / Permanent Implant	Yes	No
☐ Spine Surgery	Yes	No
☐ Trigger Point Injection – Where? _____	Yes	No
☐ Vertebroplasty / Kyphoplasty – Level(s) _____	Yes	No
☐ Other: _____	Yes	No

☐ **I Have Not Had Any Prior Treatments for My Current Pain Complaints**

Anesthesia History

Have you ever had anesthesia (sedation for a surgical procedure)? ☐ Yes ☐ No

If so, have you ever had any adverse reaction to anesthesia? ☐ Yes ☐ No

If yes, please explain: _____

Patient Name _____ **DOB** _____

Current Medications

Are you taking a prescribed **blood-thinner** medication? ☐ Yes ☐ No If yes, please check which one:

Prescribing Physician: _____

☐ Aggrenox ☐ Coumadin / Warfarin ☐ Effient ☐ Eliquis ☐ Lovenox ☐ Plavix ☐ Pleta ☐ Pradaxa ☐ Ticlid

☐ Heparin ☐ Xarelto ☐ Arixta ☐ Aspirin ☐ Advil, Aleve other NSAIDS

☐ Herbal Supplements _____

Please list ALL medications you are currently taking. Attach an additional sheet, if required.

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency
1.			7.		
2.			8.		
3.			9.		
4.			10.		
5.			11.		
6.			12.		

Allergies

Do you have any known drug allergies? ☐ Yes ☐ No

If so, please list all medications you are allergic to:

Medication Name:	Allergic Reaction Type:

Please check if you are allergic to ☐ Iodine or ☐ Tape **Are you allergic to shellfish**? ☐ Yes ☐ No

Are you allergic to latex? ☐ Yes ☐ No

Patient Name _____ **DOB** _____

Past Medical History

Mark the following conditions/diseases that you have been treated for in the past:

General Medical

- ☐ Cancer
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Liver Disease
- ☐ HIV / AIDS
- ☐ Kidney Disease

Head/Eyes/Ears/Nose/Throat

- ☐ Glaucoma
- ☐ Headaches
- ☐ Head Injury
- ☐ Migraines
- ☐ Sinusitis
- ☐ Hearing Loss
- ☐ Snoring

Gastrointestinal

- ☐ Bowel Incontinence
- ☐ Acid Reflux (GERD)
- ☐ Gastrointestinal Bleeding
- ☐ Constipation
- ☐ Opioid Induced Constipation

Respiratory

- ☐ Asthma
- ☐ Emphysema / COPD
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Valley Fever
- ☐ PE
- ☐ Obstructive Sleep Apnea

Musculoskeletal

- ☐ Amputation
- ☐ Carpal Tunnel Syndrome
- ☐ Chronic Low Back Pain
- ☐ Chronic Neck Pain
- ☐ Chronic Joint Pain
- ☐ Fibromyalgia
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Phantom Limb Pain
- ☐ Rheumatoid arthritis
- ☐ Vertebral Compression Fracture
- ☐ Reflex Sympathetic Dystrophy/CRPS

Cardiovascular / Hematologic

- ☐ Anemia
- ☐ Bleeding Disorders
- ☐ Coronary Artery Disease
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Murmur
- ☐ Pacemaker/Defibrillator
- ☐ Poor Circulation
- ☐ Stroke

Neuropsychological

- ☐ Alcohol Abuse
- ☐ Alzheimer Disease
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ Epilepsy
- ☐ Prescription Drug Abuse
- ☐ Multiple Sclerosis
- ☐ Paralysis
- ☐ Peripheral Neuropathy
- ☐ Schizophrenia
- ☐ Seizures

Past Surgical History

Please indicate any surgical procedures you have done in the past, including the date, type, and any pertinent details.

_____

_____

_____

_____

_____

_____

☐ I Have Never Had Any Surgical Procedures Done

Patient Name _____ **DOB** _____

Family History

Mark all appropriate diagnoses as they pertain to your biological **MOTHER AND FATHER** only.

	Arthritis	Cancer	Diabetes	Headaches	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Problems	Liver Problems	Osteoporosis	Rheumatoid Arthritis	Seizures	Stroke
Mother													
Father													

Other medical problems: _____

☐ I Have No Significant Family Medical History ☐ I Am Adopted (No Medical History Available)

Social History

Are you capable of becoming pregnant? ☐ Yes ☐ No **If so, are you currently pregnant?** ☐ Yes ☐ No

Highest level of education obtained: ☐ Grammar School ☐ High School ☐ College ☐ Post-graduate

Alcohol Use: ☐ Current Alcoholism ☐ Daily Limited Alcohol Use ☐ History of Alcoholism

☐ Never Drink Alcohol ☐ Social Alcohol Use

Tobacco Use: ☐ Current Tobacco User If yes, how many per day _____ ☐ Former Tobacco ☐ Never Used Tobacco

User **Prescribed Medical Marijuana:** ☐ Yes ☐ No

Drug Use: ☐ Denies Any illegal Drug Use ☐ Currently Using Illegal Drugs (Which _____)

☐ Currently Using Someone Else's Prescription Medications

☐ Formerly Used Illegal Drugs (not currently using) (Which: _____)

Have you ever abused narcotics or prescription medications? ☐ Yes ☐ No (Which: _____)

Have you ever been discharged (fired) from a pain management practice in the past? ☐ Yes ☐ No

If so, please explain here: _____

Fall Risk Assessment for patients 65 and older:

1. Have you had any falls or near falls in past year? ☐ Yes ☐ No
2. If yes, how many? ☐ 1 without injury ☐ 1 with injury ☐ 2 or more (w/o injury)
3. Are you unsteady walking or request assistances? ☐ Yes ☐ No
4. Do you use any assistive device (i.e., cane, walker)? ☐ Yes ☐ No
5. Are you often confused or disoriented? ☐ Yes ☐ No

For staff use: ** If the answer to number 2 is anything but "1 fall without injury", or there is a "yes" for questions 3-5, the patient is at risk for falls and needs a plan of care implemented. **

Patient Name _____ **DOB** _____

Review of Sypmtoms

Mark the following symptoms that you currently suffer from. Note: Diagnosed conditions/diseases should be noted under Past Medical History, on previous page.

Constitutional:	☐Chills ☐Fevers ☐Unexplained Weight Gain	☐Difficulty Sleeping ☐Insomnia ☐Unexplained Weight Loss	☐Fatigue ☐Low Sex Drive ☐Weakness	
Eyes:	☐Blurry/Double Vision ☐Eye Pain	☐Eye Redness ☐Vision Changes	☐Glasses or Contacts	
Ears/Nose/Throat/Neck:	☐Nosebleeds ☐Sinus Problems ☐Snoring	☐Dental Problems ☐Dry mouth ☐Bleeding gums	☐Earaches ☐Hearing Problems ☐Ringing in the Ears	☐Hoarseness ☐Recurrent Sore Throat
Respiratory:	☐Coughing Blood ☐Sputum Production	☐Shortness of Breath at Rest ☐Wheezing	☐Shortness of Breath upon Exertion	
Cardiovascular:	☐Chest Pain ☐Shortness of Breath while Sleeping	☐Light-headedness ☐Swelling of Legs	☐Palpitations ☐Murmur	
Gastrointestinal:	☐Changes in Appetite ☐Diarrhea ☐Vomiting	☐Changes in Bowel Habits ☐Heartburn ☐Swallowing problem	☐Constipation ☐Nausea ☐Laxative use ☐Antacid Use	
Musculoskeletal:	☐Back Pain ☐Muscle Spasms ☐Trauma	☐Joint Pain ☐Neck Pain	☐Joint Swelling ☐Stiffness ☐Joint stiffness ☐Muscle Stiffness	
Psychiatric:	☐Depressed Mood ☐Disturbing thoughts	☐Feeling Anxious ☐Mood changes	☐Stress Problems ☐Hallucinations	
Skin:	☐Dryness ☐Lumps	☐Hair Texture Change ☐Nail Texture Change	☐Itching ☐Rashes	
Neurological:	☐Dizziness ☐Instability when walking ☐Seizures ☐Weakness	☐Fainting ☐Memory Loss ☐Tingling ☐Stroke	☐Headaches ☐Numbness ☐Tremors ☐Loss of Consciousness	
Endocrine:	☐Cold intolerance ☐Heat intolerance	☐Excessive Sweating	☐Excessive Urination ☐Excessive Thirst	
Heme:	☐Bleeding Easily ☐Blood Clots			
Genitourinary:	☐Blood in Urine ☐Painful Urination			

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Patient Name _____ **DOB** _____

Over the last 2 *weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns		+	+
	TOTAL:			

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

MICHAEL A. CASTILLO, MD
Next Generation Treatment for Pain

Release of Information

Acknowledgment of Receipt of Privacy Notice

I hereby acknowledge that I have been presented with a copy of the notice of Privacy Practices and I release any and all medical information to be used in accordance with the above practice.

I authorize Michael A. Castillo, MD to discuss my medical progress with the following people.

Name & Relationship: _____

Name & Relationship: _____

Name & Relationship: _____

Name & Relationship: _____

May we leave results on your answering machine and/or voicemail? (circle one) YES NO

_____ _____

Signature (Patient or if minor Signature of parent or guardian) **Date**

MICHAEL A. CASTILLO, MD

Next Generation Treatment for Pain

Financial Policy

Thank you for choosing Michael Castillo, M.D., as your healthcare provider. We are committed to the success of your medical treatment and care. Please carefully review this Financial Policy, initial each section, and sign the agreement to indicate your acceptance of its terms.

Payment is Due at the Time of Service

1. All co-payments, deductibles, coinsurance, and fees for non-covered services are due at the time of service unless you have made payment arrangements in advance of your appointment. We accept cash, checks, and credit cards.

2. We designate accounts **Self-Pay** under the following circumstances: (1) patient does not have health insurance coverage, (2) patient is covered by an insurance plan that our providers do not participate in, (3) patient does not have a current, valid insurance card on file, or (4) patient does not have a valid insurance referral on file.

3. We request at least **24-hours** advanced notice be given to the office if you will be unable to keep your scheduled appointment. You will be charged a fee for each incident. The first incident there is a $50.00 fee, second incident has a $150.00 fee and third incident has a $200.00 fee. These charges are your personal responsibility and will not be billed to any insurance carrier. Patients who repeatedly "no show" for appointments may be discharged from the practice.

Initial:

Proof of Insurance

1. It is your responsibility to notify the Practice in a timely manner of changes in your health insurance coverage. If the Practice is unable to process your claim within your health insurance carrier's filing limits, or lack of your response to insurance carrier inquiries due to untimely notice, you will be responsible for all charges.

Initial:

Referrals & Authorizations

1. The Practice has specific network agreements with many, but not all, insurance carriers. It is your responsibility to contact your insurance carrier to verify that your assigned provider participates in your plan. Your insurance carrier's plan may have out-of- network charges that have higher deductibles and co-payments, which are your responsibility.

2. If you have an HMO plan we are contracted with, you need a referral or authorization from your primary care physician. Without an insurance required referral, the insurance company will deny payment for services. If we are unable to obtain the referral prior to your appointment, you will be rescheduled or asked to pay for the visit in advance.

3. The Practice may provide services that your insurance carrier's plan excludes or requires prior authorization. If determined that a prior authorization is required, we will attempt to obtain such authorization on your behalf. Ultimately, it is your responsibility to ensure that services provided to you are covered benefits and authorized by your insurance carrier.

Initial:

MICHAEL A. CASTILLO, MD
Next Generation Treatment for Pain

Financial Policy

Billing and Refunds

1. If we must send you a statement, the balance is due in full within 30 days of the statement date.

2. If you have an outstanding balance over 120 days old and have failed to make payment arrangements (or become delinquent on an existing payment plan), we may turn your balance over to a collection agency and/or an attorney for collection. This may result in adverse reporting to credit bureaus and additional legal action. **The Practice reserves the right to refuse treatment to patients with outstanding balances over 120 days old.** You agree, in order to service your account or to collect any amounts you may owe, we may contact you at any telephone number associated with your account, including cellular numbers, which could result in charges to you. We may also contact you by text message or e-mail, using any e-mail address you provide.

3. If you make an overpayment on your account, we will issue a refund only if there are no other outstanding balances for medical services on your account or any other account(s) with the same financial responsible party.

Initial:

Additional Information

1. The Privacy Rule allows you to receive a copy of your personal medical and billing records and allows the Practice to require individuals to complete and sign an Authorization for Disclosure and Release of Medical Records Form.

Initial:

2. The Practice will respond (at the provider's discretion) to requests for the completion of certain medical forms (FMLA, Short Term Disability & Temporary Disability Parking Permit) assuming the patient is in good standing and has been active with the Practice for six (6) months consecutively. All requests require an office visit.

Initial:

3. By initialing this section, I acknowledge that I have received and reviewed, or have been given the opportunity to receive and review, a copy of the Practice's Notice of Privacy Practice, Public, Statement of Patient's Rights and Advanced Directive Statement.

Initial:

Agreement and Assignment of Benefits

I have read and understand the Financial Policy for Michael A. Castillo, M.D., and I agree to abide by its terms. I hereby assign all medical and surgical benefits and authorize my insurance carrier(s) to issue payment directly to the Practice. I understand that I am financially responsible for all services I receive from the Practice. This financial policy is binding upon me and my estate, executors and/or administrators, if applicable.

_____ _____

Signature (Patient or if minor Signature of parent or guardian) **Date**

MICHAEL A. CASTILLO, MD
Next Generation Treatment for Pain

Patient's Rights and Responsibilities

CONFIDENTIALITY

1. It is the policy of Michael A. Castillo, MD, PC. to treat all patient information confidentially. This includes patient records and conversations. We will investigate any reported violation of this policy. If you have any questions, please ask a front desk representative for information. Dr. Castillo makes every effort to provide our patients with an environment which is safe, private, and respectful of our patient's needs. If you have a complaint about our services, facilities, or staff, we want to hear from you. We will do everything we can to see that your experience with us is professional in every way.

ISSUES OF CARE

1. Dr. Castillo is committed to your participation in care decisions. As a patient, you have the right to ask questions and receive answers regarding the course of clinical care recommended by any of our health providers, including discontinuing care. We urge you to follow the healthcare directions given to you by our providers. However, if you have any doubts or concerns, or if you question the care prescribed by our providers, please ask.

ADVANCE DIRECTIVE NOTIFICATION

1. In the State of Arizona, all patients have the right to participate in their own health care decisions and to make Advance Directive or execute Power of Attorney that authorize others to make decisions on their behalf based on the patient's expressed wishes when the patient is unable to make decisions. Michael A. Castillo, M.D., PC respects and upholds those rights

   However, unlike in an acute care hospital setting, Michael A. Castillo, M.D, PC does not perform "high risk" procedures. While no procedure is without risk, most procedures performed in this office are considered to be minimal risk.

   Therefore, it is our policy, regardless of the contents of any Advance Directive or instructions from a health care surrogate or attorney-in-fact, that if an adverse event occurs during your treatment at this office, we will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation.

PATIENT RIGHTS

1. The patient has the right to receive information from health providers and to discuss the benefits, risks, and costs of appropriate treatment alternatives. Patients should receive guidance from their health providers as to the optimal course of action. Patients are also entitled to obtain copies or summaries of their medical records, to have their questions answered, to be advised of potential conflicts of interest that their health providers might have, and to receive independent professional opinions.

2. The patient has the right to make decisions regarding the health care that is recommended by his or her healthcare provider. Accordingly, patients may accept or refuse any recommended medical treatment.

3. The patient has the right to courtesy, respect, dignity, responsiveness, and timely attention to his or her needs, regardless of race, religion, ethnic or national origin, gender, age, sexual orientation, or disability.

4. The patient has the right to confidentiality. The health provider should not reveal confidential communications or information without the consent of the patient, unless provided for by law or by the need to protect the welfare of the individual or the public interest.

MICHAEL A. CASTILLO, MD

Next Generation Treatment for Pain

Patient's Rights and Responsibilities

5. The patient has the right to continuity of health care. The healthcare provider has an obligation to cooperate in the coordination of medically indicated care with other health providers treating the patient. The health provider may discontinue care provided they give the patient reasonable assistance and direction, and sufficient opportunity to make alternative arrangements.

6. Good communication is essential to a successful health provider-patient relationship. To the extent possible, patients have a responsibility to be truthful and to express their concerns clearly to their health providers.

7. Patients have a responsibility to provide a complete medical history, to the extent possible, including information about past illnesses, medications, hospitalizations, family history of illness and other matters relating to present health.

8. Patients have a responsibility to request information or clarification about their health status or treatment when they do not fully understand what has been described.

9. Once patients and health providers agree upon the goals of therapy, patients have a responsibility to cooperate with the treatment plan. Compliance with health provider instructions is often essential to public and individual safety. Patients also have a responsibility to disclose whether previously agreed upon treatments are being followed and to indicate when they would like to reconsider the treatment plan.

_____ _____

Signature (Patient or if minor Signature of parent or guardian) **Date**

MICHAEL A. CASTILLO, MD
Next Generation Treatment for Pain

Instructions for in-office Procedures

If you and your provider have decided to do an in-office procedure, the following instructions are VERY IMPORTANT to follow. These instructions will be provided to you again upon scheduling.

BLOOD-THINNERS (ANTICOAGULANTS):
You will need your prescribing provider's permission before stopping any of the following medications, especially if you have a stent. Unless you and your provider have discussed and made prior arrangements. If your procedure is cancelled for any reason, call your provider, because you may need to restart the blood-thinning medications. The following is a list of blood-thinners and recommended timelines to discontinue prior to procedure:

14-days prior: Ticlid (ticlopidine HCL)
All over the counter vitamins/minerals/supplements

7-days prior: Trental (pentoxphylline)
Aspirin and all aspirin containing products (including Bayer, Ecotrin, Alka Seltzer, etc.)

5-days prior: Coumadin (warfarin), Plavix (clopidogrel), and Brilianta (trigrelor)

4-days prior: All non-NSAIDS COX-2 non-steroidal anti-inflammatory drug
Advil, Motin, Ibuprofen, Nuprin, Aleve, Naproxen, Relafen, Voltaren, Lodine, Mobic, etc.

3-days prior: Eliquis (apixaban), Pradax (dabigatran), Savaysa (edoxaban)

24-hours prior: Xarelto (rivaraxaban), Lovenox, Subcutaneous Heparin, Aggrenox, Persantine

Insulin Dependent Diabetic:
The recommendation is to take half the dose of your insulin on the morning of your procedure. Please bring a snack for after your procedure. If you have any questions or concerns regarding this recommendation, please reach out to your prescribing provider.

Antibiotics:
Should you start taking antibiotics prior to your scheduled procedure, please contact the office immediately. Your procedure will need to be rescheduled for 10-days after the antibiotic dose. ABSOLUTELY NO INFECTIONS!

Day of Procedure:
Take all other medication as prescribed such as blood pressure including pain medications
6-hours prior: No food or liquids other than water
2-hours prior: Nothing else by mouth including water

Sedation:
If you decide to have sedation for your procedure, please make sure you have a driver accompanying you. Public transportation is NOT allowed. NO Uber, Lyft, taxi, or bus

Please contact the office and cancel your procedure if you have no pain, have an active infection, not feeling well or if there is a scheduling conflict.

I have read and understood the instructions for in-office procedures.

Signature: **Date:**