PATIENT INFORMATION FORM

BELLA VISTA
ENT & FACIAL PLASTIC SURGERY

T: 805.494.4797 • F: 805.494.4810 • www.BellaVistaENT.com
555 Marin St., Suite 100 • Thousand Oaks, CA 91360

BVOS

PATIENT DATA

DATE:_____

Last Name:_____ First Name:_____ MI:_____

Date of Birth:_____ Social Security #:_____

Gender:_____Female_____Male Marital Status:_____

PHONE

Home:_____ Preferred Phone Number: _____Home_____Work_____Cell

Work:_____ Is it okay to leave a detailed message:_____Yes_____No

Mobile:_____

E-MAIL

E-Mail:_____ May we e-mail you for appointment reminders?_____Yes_____No

Would you like to receive our Bella Vista newsletter?_____Yes_ _No

ADDRESS

Address:_____

City:_____ State:_____Zip:_____

EMPLOYMENT

Employer:_____ Occupation:_____

INSURANCE

Primary Insurance Company:_____Secondary Insurance Company:_____

GUARANTOR/BILLING INFORMATION: SAME AS ABOVE:_____

Patient Relationship to the Guarantor:_____

Guarantor Last Name: _____ First Name:_____ MI: _____

Guarantor Date of Birth: _____ Guarantor Social Security #:_____

Guarantor Gender: _____Male _____ Female Guarantor Home Phone:_____

Guarantor Address:_____
City State Zip

PHARMACY

Pharmacy Name: _____ Pharmacy City:_____

PRIMARY CARE PHYSICIAN

Physician Name: _____Physician Phone:_____

REFERRAL

How did you hear about us? _____ Internet_____Our Website_____Insurance Company_____Advertisement:_____

Physician Referral:_____Family/Friend:_____Other:_____

EMERGENCY CONTACT

Name:_____Number:_____Relationship to Patient: _____

BELLA VISTA
ENT & FACIAL PLASTIC SURGERY

PATIENT HEALTH QUESTIONNAIRE

T: 805.494.4797 • F: 805.494.4810 • www.BellaVistaENT.com
555 Marin St., Suite 100 • Thousand Oaks, CA 91360

BVOS

All information collected in this questionnaire is strictly confidential and will become part of your medical record.

Have you had any previous surgeries? If so, what and when? (Operations and Cosmetic Surgery)

	Type	Date	Complications or Difficulties
1.			
2.			
3.			
4.			

Any medical illness or medical conditions (previous and/or current)?

Explain _____

Any admissions to a hospital ?

	Reason	Date	Complication or Difficulties
1.			
2.			
3.			
4.			

Are you currently on prescription medication? _____YES _____NO **If yes, please provide details below or attach a list.**

	Type	Dosage/Amount	Take how often
1.			
2.			
3.			
4.			

Do you take over-the-counter drugs, vitamins, supplements, or use inhalers? _____YES _____ NO **If yes, please provide details below.**

	Type	Dosage/Amount	Take how often
1.			
2.			
3.			
4.			

Do you bruise or bleed easily? (With cuts/tooth extractions/pregnancy/surgery) _ __ YES__ _NO

Explain: _____

Difficulties with local or general anesthesia? _____YES _____ NO

Explain: _____

Have you ever had a blood transfusion?_____YES _____ NO Are you Pregnant? _____YES _____ NO

Are you allergic to any medication? _____YES _____ NO **If yes, please provide details below or attach a list.**

STAFF USE ONLY:

BELLA VISTA
ENT & FACIAL PLASTIC SURGERY

PATIENT HEALTH QUESTIONNAIRE

T: 805.494.4797 • F: 805.494.4810 • www.BellaVistaENT.com
555 Marin St., Suite 100 • Thousand Oaks, CA 91360

BVOS

Past Medical History

Heart Disease _____YES _____NO
Stroke _____YES _____NO
Asthma _____YES _____NO
Diabetes _____YES _____NO
Cancer _____YES _____NO
Thyroid Disease _____YES _____NO
Kidney Disease _____YES _____NO
Sleep Apnea _____YES _____NO
GERD _____YES _____NO
Blood Disorders _____YES _____NO
High Blood Pressure _____YES _____NO

Family History

Allergy _____YES _____NO
Cancer _____YES _____NO
Diabetes _____YES _____NO
Heart Disease _____YES _____NO
Stroke _____YES _____NO
Hearing Loss _____YES _____NO
Bleeding Disorders _____YES _____NO
Keloid Formation _____YES _____NO

Social History

Alcohol _____YES _____NO
If yes, how many per day? _____ Drinks/Glasses
Smoking _____YES _____NO
If yes, how many per day? _____ Packs/Cigarettes
Illicit Drug Use _____YES _____NO
If so, explain: _____

Constitutional

Fever _____YES _____NO
Chills _____YES _____NO
Weight Loss _____YES _____NO
Night Sweats _____YES _____NO

Respiratory

Shortness of Breath _____YES _____NO
Cough _____YES _____NO
Wheezing _____YES _____NO

ENT

Hearing Loss _____YES _____NO
Sinus Pain/Pressure _____YES _____NO
Voice Change _____YES _____NO
Swallowing difficulty _____YES _____NO

Cardiovascular

Chest Pain _____YES _____NO
Ankle Swelling _____YES _____NO
Irregular Heartbeats _____YES _____NO

Ophthalmologic

Eye Pain _____YES _____NO
Double Vision _____YES _____NO
Dry Eyes _____YES _____NO

Dermatologic

Rash _____YES _____NO
Hair Loss _____YES _____NO
Growth/Spots _____YES _____NO

Musculoskeletal

Weakness _____YES _____NO
Joint Pain _____YES _____NO
Muscle Pain _____YES _____NO

Gastrointestinal

Abdominal Pain _____YES _____NO
Nausea _____YES _____NO
Heartburn _____YES _____NO

Genitourinary

Pain with Urination _____YES _____NO
Frequent Urination _____YES _____NO
Pelvic Pain _____YES _____NO

Neuro/Psych

Headache _____YES _____NO
Dizziness _____YES _____NO
Anxiety _____YES _____NO
Depression _____YES _____NO

BELLA VISTA
ENT & FACIAL PLASTIC SURGERY
T: 805.494.4797 • F: 805.494.4810 • www.BellaVistaENT.com
555 Marin St., Suite 100 • Thousand Oaks, CA 91360
BVOS

PATIENT CONFIDENTIALITY AGREEMENT

In order to comply with HIPAA standards and give our patients the best medical treatment possible, we require that a patient give us the authorization to discuss their medical records with any referring and/or referred medical providers**.**

Please list medical providers below:

Practice Name:_____

Physician Name:_____

Phone Number:_____

Practice Name:_____

Physician Name:_____

Phone Number:_____

In the event you are unable to be contacted by our office, please indicate any family member or friend that we can release any or all information relating to your medical condition.

Name:_____

Relationship to Patient:_____ Phone Number:_____

Name:_____

Relationship to Patient:_____ Phone Number:_____

Name:_____

Relationship to Patient:_____ Phone Number:_____

By signing this agreement you allow Bella Vista ENT & Facial Plastic Surgery (Dr. Glenn Waldman & Dr. Jeffrey Feinfield and their staff) access to your medical records; the release of your records to the above listed Physicians; and the release of medical information to the parties listed above.

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE

_____

PRINTED NAME

BELLA VISTA
ENT & FACIAL PLASTIC SURGERY
GLENN E. WALDMAN, M.D. & JEFFREY K. FEINFIELD, M.D.

BVOS

PRACTICE POLICIES

SHOULD YOU HAVE ANY QUESTIONS REGARDING OUR PRACTICE POLICIES PLEASE CALL US AT

(805) 494-4797 SO THAT WE MAY ASSIST YOU.

OFFICE HOURS AND MAKING AN APPOINTMENT:
The physicians at Bella Vista ENT & Facial Plastic Surgery offer several ways to request an appointment. You can make an appointment by calling our office directly, or filling out an online appointment form. Please note appointment schedules may vary depending on the doctor's surgery schedule. Follow-up appointments should be made when you check out.

Thousand Oaks
555 Marin St Suite 100
Thousand Oaks, CA
Hours: M-F:
Phone: (805) 494-4797

MISSED APPOINTMENTS/UNTIMELY CANCELLATION:
Missed appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. If you are unable to keep your appointment, please give 24-hours notice to avoid a $50 charge. This is not a billable charge to any insurance company and is the responsibility of the patient and payable at your next office visit. We reserve the right to charge for missed or untimely canceled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice. Patients who are more than 15 minutes late may have to wait until an opening becomes available or asked to reschedule.

WAITING TIME:
The physicians and staff of Bella Vista ENT & Facial Plastic Surgery make every effort to schedule patient visits according to average times needed to provide quality care for new patients and follow up visits. There can be unexpected urgent or emergent situations that may cause the allotted practice visit times to be altered or delayed. We understand that your time is important, and will make every effort to keep our schedule on time or inform you if our physicians are behind.

TELEPHONE CALLS:
In order for us to see patients at their scheduled appointment time, the doctor's do not answer calls while they are seeing patients except in emergencies. Our front desk will advise you to leave a message and a staff member will return your call by the end of the following business day at the latest.

PHYSICIAN EMERGENCY ON CALL:
For Life Threatening Emergencies, Please Dial 911. For all non-emergent issues, phone calls will be returned in the order they are received. Our paging system is available 24 hours per day 7 days a week. After hour calls are reserved for Non-Life Threatening Medical Emergencies related to the care you are receiving from the Physicians of Bella Vista ENT and Facial Plastic Surgery.

BILLING AND INSURANCE INFORMATION:
All patient-billing questions should be directed to our Billing Coordinator:

Alicia Brosius
555 Marin St. Suite 100
Thousand Oaks, CA 91361
P:805.210-5491
F:805.494.4810
E-Mail: Billing@BellaVistaENT.com

BELLA VISTA
ENT & FACIAL PLASTIC SURGERY
GLENN E. WALDMAN, M.D. & JEFFREY K. FEINFIELD, M.D.

BVOS

FINANCIAL POLICY:
We are committed to providing you with the best care possible. In order to achieve this goal we are in need of your assistance and understanding of our financial policy. The physicians at Bella Vista ENT & Facial Plastic Surgery participate with most major insurance companies. When scheduling any type of appointment with our physicians, we will need to verify your insurance coverage. Please have your insurance card(s) available when scheduling appointments, as you may be asked to re-verify information to guarantee coverage. Our office individual coverage varies within our contracts and your coverage is an agreement between you and your health insurance company. It remains your responsibility to verify that the care you receive is covered by your health plan.

•We have made prior arrangements with insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment and/or deductible at the time of service. This office has the policy to collect this co-payment and/or deductible when you arrive for your appointment.

• If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of service.

• Our billing department will not become involved in disputes between you and your insurance company regarding uncovered charges, coordination of benefit issues, eligibility issues, or pre-existing conditions which cause the claim to be denied. Should your claim be denied for any of these reasons, the claim will become the responsibility of the patient and payment will be expected within 30 days.

•(Medicare patients) -since our office accepts Medicare assignment; we will bill Medicare for you. Patients who have only Medicare are responsible for the co-insurance portion approved by Medicare. If you have a secondary insurance, we will also bill them for you.

PAYMENT OPTIONS:
For your convenience, we offer a variety of payment options. We accept Visa, MasterCard, and Discover credit cards, checks, and cash. All returned checks will be assessed a $25.00 returned check fee in addition to the original charge.

ADDITIONAL OFFICE CHARGES:
In addition to office consultations, procedures may be performed, if needed, at the time of service. Examples of these procedures are nasal endoscopy, video stroboscopy, flexible laryngoscopy, nasal cautery and the use of an operating microscope. Please be assured that our office is following accepted billing and coding guidelines and that all procedures performed are in the best interest of patient care. These services are an additional fee, and the patient's cost may vary depending on their insurance company. Many insurance companies will label these procedures as a "surgical code", and apply it towards a patient's deductible or yearly out-of-pocket maximum amount. Patients will be responsible for this amount at the time of service.

IN-OFFICE COSMETIC APPOINTMENTS:
Our Physicians provide one cosmetic consult per patient free of charge. A credit card is required to be placed on file for this and any other cosmetic appointment (photo-morphing, injectibles, chemical peels, etc.) as a gracious amount of time is set aside for these appointments. Payment for these in-office cosmetic procedures is required in full on the date of service. No-shows and cancellations made less than 24 hours in advance will be charged a **$250.00 fee.**

SURGICAL APPOINTMENTS:
Our surgery coordinator will discuss your insurance benefits prior to scheduling your procedure. When scheduling a cosmetic surgery, a $500 non-refundable deposit is required to reserve your desired date. Any co-payment, deductible, co-insurance, or cosmetic fees need to be paid in full two weeks prior to your surgery date. If financing is needed, we are partnered with CareCredit Inc., who provides multiple payment options. If state or work disability-related paperwork needs completion, the patient will be charged a $30.00 document fee.

TERMINATION POLICY:
Termination notes will be placed in each patient's file and these notes will reflect both the reason for termination, as well as whether it was a mutual or unilateral decision on the part of the patient. If you request further treatment, a recommendation will be made to direct you to three other local practitioners for follow-up care. Any unpaid balance at the termination of treatment will be the responsibility of the patient.

BELLA VISTA
ENT & FACIAL PLASTIC SURGERY
GLENN E. WALDMAN, M.D. & JEFFREY K. FEINFIELD, M.D.

BVOS

PATIENT INFORMATION CONSENT/DISCLOSURE FORM

The following are the conditions for services provided by the physicians of Bella Vista ENT & Facial Plastic Surgery for the patient whose name appears below. **Please read carefully and *initial each section*, if a section does not apply to you mark N/A.** Should you have any questions, please call us at (805) 494-4797 so that we may assist you

Patient Name _____ Date _____

X _____
Signature

CONSENT FOR MEDICAL TREATMENT

I hereby voluntarily consent for care encompassing diagnostic procedures and treatment by my physician, and his staff, including but not limited to, physician assistant, nurse practitioner, designees or consultants, as may be necessary in the judgment of my physician.

I am aware that follow up office visits are required to review the results of diagnostic or therapeutic tests. I understand that I cannot assume that my test results are normal until they are thoroughly reviewed with the doctor. I further acknowledge that it is my responsibility to make appropriate follow up visits with my Physician to maximize improvement in my condition.

X _____

RELEASE FROM RESPONSIBILITY

If I should leave the practice against medical advice or prior to treatment being completed, I hereby relieve said physician and the Clinic of all liability for my action.

X _____

PHYSICIAN AS INDEPENDENT CONTRACTOR

I understand that each practitioner is an independent contractor at Bella Vista ENT and Facial Plastic Surgery.

I recognize that medical and surgical services provided by my physician are independent of, and will be billed separately from, other physicians or facilities. At times my physician may refer me to a physician or facility to assist in the best care of my condition. I understand that these providers may or may not be in network or participate with my insurance policy. It is my responsibility to verify that the care that I receive is covered by my health plan for each physician, and facility.

Imaging tests, lab tests, Audiology, or similar studies may be ordered during the course and treatment of my condition. Those facilities are independent and financially separate from this practice.

X _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the Clinic or the Clinic's designee to disclose to payors including, but not limited to, insurers, the Centers for Medicare Services, or any other parties that may be liable for all or part of the Clinic charges ("Third Party Payors"), all or part of my medical records as may be necessary to process payments for health care services provided. I authorize these payors to pay directly to the Clinic. I also authorize the Clinic to utilize my medical information, or to release all or part of my medical information to other health care providers consulted by my physician or the Clinic, as may be necessary. I understand that the Clinic will take actions in reliance on this authorization to release medical information and that this information will be released only as necessary to carry out treatment, payment or Clinic operations.

X _____

ACKNOWLEDGEMENT OF GENERAL OFFICE POLICIES

I have read and understand the general office policies, and agree to the arrangements outlined.

X _____

PATIENT INFORMATION CONSENT/DISCLOSURE FORM

ACKNOWLEDGEMENT OF FINANCIAL POLICY

Bella Vista ENT & Facial Plastic Surgery is dedicated to providing our patients with the best possible care and customer service. We ask for your help by understanding and cooperating with our financial policy. We must emphasize that as physicians, *our relationship is with you*, NOT your insurance company. While the filing of insurance claim is a courtesy that we extend to our patients, all charges are strictly your responsibility .The Physicians at Bella Vista ENT & Facial Plastic Surgery have provider contracts with some insurance carriers, however our office individual coverage varies within our contracts and your coverage is an agreement between you and your health plan/health insurance company. It remains your responsibility to verify that the care you receive is covered by your health plan/health insurance. This office is not responsible for the expense of treatment not paid by your health plan/health insurance. With continuous changes in coverage, you should verify your benefits and understand all requirements of your health plan/health insurance by calling the customer service number located on your health plan/health insurance card. When Bella Vista ENT & Facial Plastic Surgery does not have a contract with your health plan/health insurance carrier you will be responsible for the entire amount at the time services are rendered. Your initials on this Financial Policy will be your acknowledgement that you are aware of your benefits and our financial policy.

X_____

NO INSURANCE COVERAGE (SELF PAY)

The patient or guardian will be responsible for payment, which may include diagnostic or therapeutic tests at the time of service, as well as the office visit charge.

X_____

ASSIGNMENT OF INSURANCE BENEFITS

I herby assign to the Physicians and Bella Vista ENT & Facial Plastic Surgery all rights, title, and interests in the benefits payable to me by an insurance policy(ies) or benefits plan under which I am covered for services rendered by the physician. I understand that I am responsible for all charges not covered by the assignment along with any deductibles and/or co-insurance and hereby promise to pay any remaining balance. For Medicare beneficiaries: I have provided all necessary information for proper assignment of Medicare benefits.

X_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. I understand that Bella Vista ENT & Facial Plastic Surgery has reserved a right to change its privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me upon request.

X_____

CANCELING AN APPOINTMENT/NO SHOW/LATE POLICY:

Patients who do not keep their medical appointments or provide 24-hour notice of cancellation will be subject to a charge of $50.00. This fee will be applied after the first missed appointment or first failure to provide 24-hour notice. This is not a billable charge to any insurance company and is the responsibility of the patient. If a patient misses or cancels 4 times, we reserve the right to dismiss that patient from the care of Bella Vista ENT & Facial Plastic Surgery.

IN-OFFICE COSMETIC APPOINTMENTS:

A credit card is required to be placed on file for this and any other cosmetic appointment as a gracious amount of time is set aside for these appointments. Payment for these in-office cosmetic procedures is required in full on the date of service. No-shows and cancellations made less than 24 hours in advance will be charged a $250.00 fee.

X_____

PHOTO / VIDEO RELEASE:

I understand that all preoperative and postoperative photos and/or videos will be the property of Bella Vista ENT & Facial Plastic Surgery. I consent to the use of these photos and/or videos for the purpose of patient education, physician conferences, and marketing purposes.

X_____

BELLA VISTA
ENT & FACIAL PLASTIC SURGERY
GLENN E. WALDMAN, M.D. & JEFFREY K. FEINFIELD, M.D.

Sino-Nasal Outcome Test (SNOT-22) Questionnaire

Patient Name: _____ **Date**: _____

Below you will find a list of symptoms and social/emotional consequences of your nasal disorder. We would like to know more about these problems and would appreciate your answering the following questions to the best of your ability. There are no right or wrong answers, and only you can provide us with this information. Please rate your problems as they have been over the past two weeks. Thank you for your participation.

A. Considering how severe the problem is when you experience it and how frequently it happens, please rate each item below on how "bad" it is by circling the number that corresponds with how you feel using this scale:

	No Problem	Very Mild Problem	Mild or Slight Problem	Moderate Problem	Severe Problem	Problem as bad as it can be	Most important items
1. Need to blow nose	0	1	2	3	4	5	[ ]
2. Sneezing	0	1	2	3	4	5	[ ]
3. Runny nose	0	1	2	3	4	5	[ ]
4. Nasal obstruction	0	1	2	3	4	5	[ ]
5. Loss of smell or taste	0	1	2	3	4	5	[ ]
6. Cough	0	1	2	3	4	5	[ ]
7. Post-nasal discharge	0	1	2	3	4	5	[ ]
8. Thick nasal discharge	0	1	2	3	4	5	[ ]
9. Ear fullness	0	1	2	3	4	5	[ ]
10. Dizziness	0	1	2	3	4	5	[ ]
11. Ear pain	0	1	2	3	4	5	[ ]
12. Facial pain/pressure	0	1	2	3	4	5	[ ]
13. Difficulty falling asleep	0	1	2	3	4	5	[ ]
14. Waking up at night	0	1	2	3	4	5	[ ]
15. Lack of a good night's sleep	0	1	2	3	4	5	[ ]
16. Waking up tired	0	1	2	3	4	5	[ ]
17. Fatigue	0	1	2	3	4	5	[ ]
18. Reduced productivity	0	1	2	3	4	5	[ ]
19. Reduced concentration	0	1	2	3	4	5	[ ]
20. Frustrated/restless/irritable	0	1	2	3	4	5	[ ]
21. Sad	0	1	2	3	4	5	[ ]
22. Embarrassed	0	1	2	3	4	5	[ ]
TOTALS (each column):							

GRAND TOTAL SCORE (all columns together): _____

B. Please check off the most important items affecting your health in the last column (max of five items)

BELLA VISTA
ENT & FACIAL PLASTIC SURGERY
GLENN E. WALDMAN, M.D. & JEFFREY K. FEINFIELD, M.D.

BVOS

Credit Card Payment Authorization Form

Dear Patient,

This letter is to inform you of our billing guideline that our office has implemented in order to reduce the need for phone calls and billing statements from our office staff regarding a balance on your account. It is our policy to have a valid credit card on file. It is kept on site and stored in a HIPAA compliant program. Your credit card will be charged on the last day of the month if you have an open balance (Co-Pay, Co-Insurance, Deductible, Non-Covered Service, No-Show Fee, Surgery/Procedure Cancellation Fee, etc). A receipt of payment will be kept on file, and is available to you upon request.

I, _____, authorize Bella Vista ENT & Facial Plastic Surgery, BVOS, Glenn Waldman, M.D. & Jeffrey Feinfield, M.D. to charge my credit card for any outstanding balance on my account in full (unless other arrangements have been made) on the last day of every month, and as long as an open balance remains. With the exception of, No-Show, Appointment and Surgery/Procedure Cancellation Fee`s, which will be charged 24 hours after appointment on the following credit card:

Please Circle One: VISA MasterCard Discover

Credit Card#:_____ Expiration Date: _____

CVV-Security Code: _____ Name on Card: _____

Billing Zip Code: _____

Signature: _____ Date: _____

Patient(s) Name(s): _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the outlined above. I certify that I am the authorized user of this credit card and that I will not dispute the payment with the credit card company; so long as the transaction corresponds to the terms indicated in this form.

Bella Vista ENT & Facial Plastic Surgery
Glenn Waldman, M.D. & Jeffrey Feinfield, M.D.
555 Marin Street Suite 100 Thousand Oaks, CA 91360
805-494-4797

Bella Vista ENT Plastic Surgeons
555 Marin St Suite 100
Thousand Oaks, CA 91360

I have been informed of my right to formulate an Advanced Directive, and I have been provided with information regarding the execution of an Advanced Directive.
Please Select One:

☐ I have previously completed an Advanced Directive and have provided a copy of inclusion in my medical record

☐ I will provide a copy of my previously executed Advanced Directive to Bella Vista ENT for Inclusion in my medical record

☐ A copy of my Advanced Directive is on file with: _____
Name of Provider or Health Care Facility

☐ I have not executed an Advanced Directive and I am not interested in any further information

☐ I am interested in formulating an Advanced Directive and will discuss my options with my primary care physician

Patient Signature: _____ Date: _____

Patient Name (Print): _____

Comments: Include steps taken to obtain a copy of Advanced Directive

_____

_____

_____

☐ A copy of the Advanced Directive has been requested

Signature of Group Representative: _____ Date: _____