|  |  |  |  |
| --- | --- | --- | --- |
| ${logo} | | | |
| Medical History | | | |
| **Full Name** | ${name} | **Do you have Insurance?** | ${insurance} |
| **Gender** | ${gender=male} Male ${gender=female} Female | **Do you have Secondary Insurance?** | ${secondary-insurance=yes} Yes  ${secondary-insurance=no} No |
|  | | | |
| ${acknowledgement} | | | |
|  | | | |
| **Name:** ${name} | | | |
| **Date:** ${sign-date} | | | |
| **Signature**: ${signature} | | | |