Sesi Signature Inc.

Follow Up Visit / Change in Medical History

1. **Patient Information**

Name: _____

Date: _____

Address:

_____

Phone: _____

Email: _____

Has your health situation changed at all since your last visit?

Yes _____ (fill out new health history document)

No _____

I understand that if my health history has in fact changed, and I have not informed my healthcare provider, the healthcare provider is not responsible for any liability.

Signed: _____

Dated: _____