Last Name:

First Name:

Age:

DOB:

Phone:

Email:

Address:

Days and times available for appt:

Notify openings from cancellations?

Emergency Contact:

Emergency Contact Phone Number:

Health Concerns:

Date of Onset:

Allergies:

Breastfeeding?

List all Medications:

Vaccines and dates:

Antibiotics and dates:

Supplement #1:

 Brand:

 Dose:

 Date Started:

 Notice if help?

Supplement #2:

 Brand:

 Dose:

 Date Started:

 Notice if help?

Repeat for other supplements:

Supplements: \_\_ Interested in purchasing at visit \_\_ prefer link to order later \_\_ not interested

Testing interested in: \_\_food/yeast ($183.35) \_\_hormones-blood ($129)

\_\_hormones-DUTCH($300) \_\_thyroid ($75.56) \_\_nutrients ($varies) \_\_mold testing ($87.97)

Occupation:

How did you hear about Dr. Lee?

Will you be submitting receipts to insurance?

Need garage door open to avoid stairs?

***Clinic Policy requires payment at time of services. Please cancel 24 hours in advance. If you do not cancel 24 hours in advance for return visits, you will be charged $30.***

Signature:

Date: