Patient Intake Form

Patient Name: (Last) _____ (First) _____ (MI) _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cellular: _____
Birthdate: _____ Age: _____ Sex: M F
Email: _____
Any drug allergies? Y /N If yes please list _____
Are you currently taking any medication? Y / N If yes please list _____
List any Surgeries:_____
Do you have: chronic kidney disease Y / N High blood pressure Y / N Heart disease Y / N
Asthma Y / N Diabetes Y / N ↑ cholesterol Y / N
Are you being treated by a physician for any medical problems? Y / N. If yes, for what? _____
_____

Emergency contact Information:

Name: _____ Phone _____

Relationship: _____

I voluntarily request and consent to a Vitamin B12 / MIC Combo/MICUltra fat burner injection

Patient signature: _____ Date: _____

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