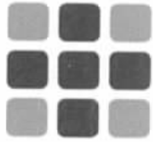

Total Health & Wellness

RESTORE | RECOVER | RENEW

****Please complete & return to front desk with insurance cards****

*** Thank You***

PATIENT INTAKE INFORMATION

Name: ____
(Last) (First) (M.I.)

Address: ____
____
____

Phone: ____________________ Mobile: ____________________
Email: ____________________ Height: ____________________
D.O.B.: ____________________ Weight: ____________________

Emergency contact: ______________________________________
Address and ______________________________________
Phone # ______________________________________
____

Prescribing M.D.: ______________________________________
Phone number: ______________________________________

***If you are not the subscriber for your insurance, please indicate the subscriber name and date of birth.

Subscriber name as it appears on ins. card: ____________________________
Subscriber D.O.B.: ______________________________________
Relationship: ______________________________________