



Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS# \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home: \_\_\_\_\_

Email address: \_\_\_\_\_

Pharmacy & Location: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

**Consent to Treatment:**

X \_\_\_\_\_ Date: \_\_\_\_\_