

# PATIENT INTAKE FORM

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

ADDRESS/CITY/ZIP: \_\_\_\_\_

HOME: (        ) DOCTOR NAME: \_\_\_\_\_

EMAIL: \_\_\_\_\_ BIRTHDAY: \_\_\_\_\_

CREDIT CARD: \_\_\_\_\_ EXP DATE: \_\_\_\_\_

By signing this, I authorize my practitioner to charge me for products indicated

BEEN TESTED BEFORE?  YES  NO MEDICATIONS?  
(Continue on back)

I acknowledge that any suggested nutritional advice or dietary advice is not intended as any primary treatment and or therapy for any disease or particular bodily symptom. Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and bio-mechanical processes of the human body. The technician is not diagnosing, curing or treating any disease.

\_\_\_\_\_  
Patient Signature

PRODUCT NAME	PRODUCT NUMBER	QTY	PRICE

<b>SPECIAL INSTRUCTIONS-DOCTOR:</b>	<b>MERIDIAN ASSESSMENT</b>	<b>\$</b>
	<b>SUBTOTAL</b>	<b>\$</b>
	<b>TAX</b> <span style="color: red; font-size: small;">(Required for Illinois Residents %6.5)</span>	<b>%</b>
	<b>TOTAL</b>	<b>\$</b>

Detach for Patient and Staple to Printout

<b>SPECIAL INSTRUCTIONS-PATIENT:</b>	<div style="border: 1px solid black; width: 100%; height: 30px; margin-bottom: 5px;"></div> <b>TECHNICIAN NAME</b> <div style="border: 1px solid black; width: 100%; height: 30px; margin-bottom: 5px;"></div> <b>RETEST DATE</b>	Patient Name: _____ Patient Total: <b>\$</b> _____ Date: _____ Doctor Name: _____ Supplement Pickup Date: _____	
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Thank-You for Your Order!  
KEEP THIS RECEIPT