Name ______________________________ Date ______________

Parent Name (if applicable)______________________________

Address ______________________________

Phone ____________________(H) ____________________(O)

Email ______________________ Date of Birth ______________

Occupation / School ______________________________

How did you hear of our services? ______________________________

Reason for Visit and/or Diagnosis ______________________________

____

Name / Address for Person Responsible for Payment ______________________________

____

Are you a Medicare Beneficiary? YES NO Are you a Medicaid Beneficiary? YES NO

Current Medications ______________________________

____

Vitamin/Mineral/Supplements ______________________________

____

Raleigh Office: 1042 Washington Street, Raleigh, NC 27605
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