IF YOU ALREADY HAVE A LIST WE WOULD BE HAPPY TO PHOTOCOPY IT

NAME: (Print) _____ **BD:** _____

MEDICAL HISTORY

Do you have any of the following:

Diabetes	Stroke	High Blood pressure	Are you pregnant?
Blood borne disease	Heart Disease	Cancer (type): _____	
Seizures	Asthma	Arthritis	Polio
Metal implants	Heart Attack	Pacemaker	Multiple Sclerosis
Numbness / tingling (where)_____			Parkinson's
Dementia	Joint Replacements:_____		

Please list any other pertinent medical information _____

_____

_____

_____

MEDICATIONS

Name	Dosage	Frequency	Administration (oral / injection …)

Cancellation / No Show Policy / Insurance

We require **12-hour advance notice** of a cancelled or rescheduled appointment. If 12-hour notice is not given, we will charge a $25.00 fee for the missed appointment. Insurance companies **DO NOT** pay for this charge; therefore you will be responsible for that charge. There will be a charge of **$25.00** for a check returned for **NSF**.

I HAVE READ AND UNDERSTAND THE ABOVE POLICIES AND FEES:

Signature_____ Date_____