

# Patient Information Form

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

Date of Birth: \_\_\_\_\_

Phone: \_\_\_\_\_

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

## Medical History

☐ Diabetes

☐ Heart Disease

☐ High Blood Pressure

## Consent

☐ I consent to treatment

Signature: \_\_\_\_\_

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