OPTIMAL T CENTER

PATIENT INFORMATION

NAME:_____ SEX: M F DOB _____

ADDRESS: _____ APT#_____ CITY, STATE, ZIP _____

CONTACT NO _____ EMAIL _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? Y OR N
IF YES, LIST _____
ARE YOU CURRENTLY ON ANY WEIGHT LOSS MEDICATION? (OVER THE COUNTER OR PRESCRIBED)
IF YES, LIST _____
IS THERE A CHANCE YOU ARE PREGNANT? Y OR N NOT SURE

PATIENT CONSENT TO TREAT

I authorize the Medical Staff from Optimal T Center to obtain my information and to administer an injection of an Energy, Vitamin, or Performance Enhancing solution, none of which is a controlled substance. By signing this agreement, I am stating that I am of age to make an informed consent decision on my own behalf.

_____ _____

Signature **Date**

Optimal T Center will not release any information to any individual or facility regarding this patient. The information obtained on this form will remain in Optimal T Center's records for any and all services received from the Optimal T Center Medical Staff only. Initials _____