Gloria Tucker MD

Diplomate of the American College of Sports Medicine

Name_____Date_____

Address_____

City_____State_____Zip Code_____

Email_____phone(H)_____(c)_____* Is it ok to leave a message that may contain personal health information? Yes/no

Birthdate_____Age_____Sex_____

Occupation_____Employer_____

Who may we thank, in your name, for referring you?_____

(We offer 10% off for the next treatment of your referring friend)

Who to call in case of Emergency?_____

Phone Number_____2nd phone_____.

Are you on blood thinners? Y/N For what condition?_____

Are you interested in taking a mild pain medicine before the procedure? Y/N If so please arrange this at your consultation.

Do you have any allergies? _____

Any heart disease?_____ stroke?_____seizure?_____

Do you smoke? Y/N How much?_____Drink? Y/N How much? _____

IT IS VERY IMPORTANT THAT YOU READ "BEFORE YOUR PROCEDURE" AND "AFTER YOUR PROLOTHERAPY TREATMENT" ON OUR WEBSITE AT www.gloriatuckermd.com

****We are continually striving for better service. Would you mind if we emailed you in order to hear about your experience? _____ No, I don't mind _____ Yes, I would not like it**

Our Fees are due and payable at the time of service. There is a 10% late fee after 1 month.

Signature_____