SPECTRACELL TESTING – INTAKE FORM

Patient Demographics:

Patient's Name : _____ D.O.B._____

Gender: □ Male or □ Female Primary Care Physician:_____

Height:_____ft _____in Weight:_____-lbs

Address: _____

City:_____ State:_____ Zip:_____

Home Phone: _____ Cell Phone: _____

E-mail: _____ Drug Allergies: _____

Payment Method: □ Check #_____ □ Credit Card

□ Visa □ Mastercard □ AMEX □ Discover

Credit Card # _____ Exp: _____Sec Code:_____

Cardholder Name: _____

Insurance information: PLEASE ATTACH FRONT AND BACK COPY OF CARD

Test To be completed □ Micronutrient $150 (**with insurance price**) □ Micronutrient $260 (**Cash price)**

Symptoms/complaints :

□ Fatigue (R51.83)
□ Depression (F32.9)
□ unexplained weight gain (R63.5)
□ unexplained weight loss (R63.4)
□ Vitamin Deficiency (E63.9)
□ Headaches (R51)
□ ADD (F90.9)
□ Hypothyroidism (E03.9)
□ Type 2 Diabetes (E11.9)
□ Hyperlipidemia (E78.5)
□ Other:_____
□ Other _____