CLIENT INFORMATION

Name:_____

Address:_____

City:_____ State:_____Zip Code:_____

Date Of Birth:_____ Age:_____

Male:_____ Female:_____

Home Phone:_____ Cell Phone:_____

Email Address:_____

Emergency Contact:
Name/Relationship_____

Known Allergies: (food, drugs, Vaccines, an/or environmental):_____

_____

_____

HBOT Treatment will be denied if you are taking the following medications:
Bleomycin, Disulfiram, Mafenide Acetate. HBOT Treatment will be denied if you have or suspect the following: COPD, Hereditary Spherocytosis, an Sickle Cell Anemia

What is your primary reason for coming to Hyperbaric Med Spa?_____

_____

How did you hear about Hyperbaric Med Spa?_____

Who may we thank for referring you?_____