At Live Well, we take your privacy seriously.
Please help us to do this by providing the following information:

<u>**Live Well does NOT share, sale, or distribute your information**</u>

Legal Name_____

Date of Birth _____

Physical Address (No P.O. Box)

_____

_____

Phone _____ Cell _____

Email_____

Emergency contact_____

Phone_____

May we leave a message when we call this phone number?

_____

Employer_____
Occupation_____

How did you hear about us? _____

Primary Care Physician _____

Have you ever served in the military? yes ( ) no ( )

I am aware that the procedures may not be covered by insurance or Medicare. I am aware that I am responsible for all cost associated with the procedure at time of service.

Signed_____ Date _____