Rose Blanche Wellness Acute Email Intake Form

Name: _____ Date of Birth: D_____ M_____ Y_____

Address: _____

Telephone: Home: _____ Work: _____ Cell:_____

E-mail Address: _____Emergency Contact: _____ _ ____

Referred By: _____ Present M.D. and Phone #:_____ _____ _

Medical/Professional Waiver PLEASE READ THE FOLLOWING CAREFULLY (if under 18 years of age, a parent or guardian must sign.) I, the undersigned, understand that Ashley Mendoza is a homeopath and not a licensed medical doctor. As such, I acknowledge that it is my responsibility to seek medical diagnosis and advice for my present and future conditions. In consulting with Ashley Mendoza, I am exercising my right to choose an alternative method of treatment through which to address my total health. As homeopathy is not covered by the existing government medical insurance plan, I agree to pay all fees presented in the current rate schedule. I acknowledge that all personal information will be kept confidential. I consent that from time to time I may receive e-mails from Ashley Mendoza and/or Rose Blanche Wellness which will provide me with relevant health information/newsletter, upcoming events, homeopathic and natural health seminars and learning opportunities. I understand that I can unsubscribe to these e-mails at any time.

Patient Signature: _____ Date:_____