PASSER RESTORATIVE THERAPIES
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Name: Birthdate:

Do you have any medication allergies? ◯ Yes ◯ No
If yes, please list them here:

Please list ALL medications and supplements you are currently taking.

Name of Medication/Supplement:	Dose:	Directions:
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		

My medications are correct, and I authorize PASSER RESTORATIVE THERAPIES to access my medication(s) history.

Signature: Today's Date:

Please list your preferred pharmacies & their address/intersection:
Pharmacy 1:
Pharmacy 2: