Mavrick Lobe DOM Rx2 Santa Fe, NM
Intake Form

Date: ___________Patient's name: __________
Male: ____ Female: ___ Age: ___Birth date: _________________
Contact numbers: (H)_________(Cell): ________________ e-mail: _________________
Home address: ____
Occupation___________________________
Who referred you to our office _____________________________
In the case of an emergency, whom should we contact? _______________Phone_____________
Main Complaints, how long has it been going on?
1. ____
2. ____
3. ____
4. ____
Minor Complaints: Are there other symptoms that we may be able to help you with?
1.____
2. ____
3. ____
4. ____
Major Illness in the past: Please state the type of illness and your approximate age
1. ______________________________ 2. __________________________________
Allergies:
_________________________________ ____________________________________

_________________________________ ____________________________________
Prescription medicine: Please state the medication and reason for taking it.
_________________________________ ____________________________________

Herbal and vitamin supplements?
_________________________________ ____________________________________

INFORMED CONSENT FOR TREATMENT BY MAVRIN LLC

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended treatments and procedures to be used so that you make an informed decision whether or not to undergo the recommended procedure(s) after knowing the benefits and risks involved. This notice is not meant to alarm you; it is simply to inform you that you may give or withhold your consent to treatment.

I voluntarily request Dr. Lobe as my physician, to examine and treat me and my health conditions. I understand that the course of care therapy may include the use of multiple modalities of Chinese medicine including nutritional supplements, bio-identical hormones, injection therapies, prolotherapy, Platelet Rich Plasma, Stem cell therapies, intravenous nutrients, chelation, spinal manipulation, body work, and other therapies offered at Mavrin LLC. I understand that my verbal consent to a specific

treatment and my willing participation in receiving these therapies after explanation of benefits and risks is sufficient to indicate my consent to receive treatment. I waive the option of signing a consent to treat for each and every specific procedure at each treatment date.

I understand that I am free to pursue other medical opinions and treatments including conventional medical care at any time. I understand that I have the right and the opportunity to ask questions about my condition, discuss alternative and conventional options at any time. I understand there may be complications and risks related to the recommended procedure(s) and that I may request additional information regarding complications and risks (side effects) and refuse any specific treatment at any time.

I understand that no warranty or guarantee regarding a promise of cure as a result of care is provided for any condition.

All information given now or at any point in the future is confidential. It is MavrinLLC's policy to require a medical release form before releasing medical records to anyone other than the patient.

I certify that I have read this form, or have had it read to me, and that I understand its content and meaning. I have sufficient information to give this informed consent.

Patient Name __________________ Date_______

Signature______________________

Witness_________________________

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