PATIENT SUPPLEMENT VERIFICATION FORM

PATIENT NAME:_____ **DATE OF BIRTH:**_____

SUPPLEMENT NAME	DOSE/STRENGTH	FREQUENCY	PRESCRIBING PHYSICIAN	DATE OF LAST REFILL

Once you have completed this form, please feel free to email it to sdowling@ifsmed.com before your next scheduled appointment. A copy of your supplement form will be saved to your medical record. Our medical staff will have access to your supplement list during your upcoming appointments; changes and updates will be made during your appointment if necessary. If you are unable to email this form, please be sure to bring it in with you during your next scheduled appointment. If you fail to supply our medical office with an updated supplement form, you will be asked to reschedule your appointment until we have an updated form. If you should require assistance with filling out this form, please bring in all your supplements and we will be happy to assist you. It is our #1 priority to provide our patients with the utmost medical treatment and care, if we are not aware of your current supplement regimen, it can potentially become harmful if not life-threatening to the treatment we offer you in our facility.