



Patient Information

Last Name: _____ First Name: _____

Date of Birth: ___ / ___ / _____ Gender (Please circle): M F

Height: ___' ___" Weight: _____lbs.

Phone Number: () ___ / _____ E-Mail: _____

Healthcare Facility Information

Facility Name: _____ Provider: _____

Address: _____ State: _____ Zip Code: _____

Phone Number: () ___ / _____ E-Mail: _____

I would like to receive the test results by (select one):

- E-mail First Class Mail

Method of Payment (cost \$150.00)

- Check Enclosed

Amount: \$ _____

- Credit Card

CC#: _____ - _____ - _____ - _____

Exp: ___ / _____ CSC code: _____