

Name: _____

Street Address: _____

City: _____ Postal Code: _____

Home Phone: _____

Work Phone: _____

Occupation: _____

Date of birth: _____ Age: _____

Referred by: _____

Present M.D.: _____

M.D. Phone: _____

I, the undersigned, understand that Roma Lahiri is a professional homeopath trained in the classical tradition and that she is 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 a professional homeopath I am exercising my right to choose an alternative method of treatment through which to address my total health.

Signature _____

Date _____