LANGTON
SMITH HEALTH

TITLE	First Name	Last Name	

Full Address

Phone	Mobile	Email
Date of Birth	Place of Birth	Country of Birth
Male/Female	Height	Weight

Occupation	GP Name/Address

Brief Medical History:

Primary Reason for Test:

Specify test required: ie: Wheat. Dairy. IBS,,,,

Payment Method: Paypal; Invoice; Credit Card……

I give permission for (name of business) to hold my personal details as stated on this health form for a period of 12 months for the purpose of Bioresonance health scanning. I understand that the method of a health test involves this personal data being placed into a medical scanning device to obtain results. The Bioresonance scanning device holds a database for the purposes of future scanning and data is held on this device until you have informed us in writing that you wish us to delete it. No hair samples are kept as when they are scanned they are immediately destroyed. All children under the age of 18yrs must have this form signed by a parent or legal guardian.

Signed……. Date……..

REMEMBER TO ENCLOSE A SMALL SAMPLE OF HAIR OR FINGERNAILS (APPROX 10 HAIRS 1 CM OR 1⁄4 INCH LENGTH MINIMUM)

Please send the completed form and hair sample to:

Langton Smith Health, 37 Surrey Street, Littlehampton, West Sussex, BN17 5BH