Name: _____ Date: _____

We would like to communicate with your health care providers and work together on your journey to wellness. Please provide basic contact information below. **Fill out as much as you can.** We understand it is sometimes difficult to remember details of your health providers such as addresses and phone numbers, but just do the best you can!

By filling out this form, you are authorizing Community Chiropractic to contact other health care professionals regarding your care in this office. Your health information may be shared with these professionals.

_____ _____

Patient Signature Date

Medical Practitioner (MD, DO, LNP)

- Name:
- Address:

- Phone:

Dentist

- Name:
- Address:

- Phone:

Physical Therapist/Occupational Therapist/ Acupuncturist

- Name:
- Address:

- Phone:

Yoga/Massage Therapist/Personal Trainer

- Name:
- Address:

- Phone:

Any other specialist that you regularly visit

- Name/profession:
- Address:

- Phone: