Professional Medical Release

Name: | Address:

Phone Number: | E-mail: | Birth Date:

Sex: | Marital Status: | Primary Care Physician:

Phone Number: | Previous Chiropractic Treatment: | Referred by:

Work Information

Employer: | Address:

Phone Number: | Occupation:

Spouse Information/Policy Holder

Full Name: | Birth Date: | Occupation:

In case of Emergency

Contact: | Phone Number: | Relationship:

I understand and agree to authorize the company, and/or other doctors/staff to administer examination procedures and treatments, as deemed necessary:

Signature: | Date:

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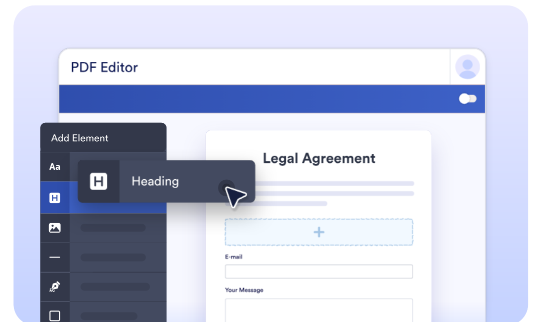

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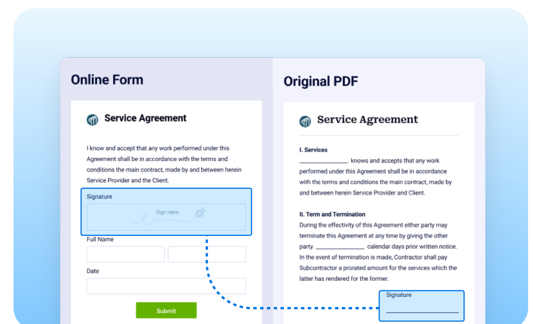

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