Patient Physicians

To better coordinate your care, we would like to inform your medical providers with information regarding our findings, treatment, and results. Please be sure to list your primary care physician and family dentist.

Patient Name: _____

Date: _____

Family Physician
Name: _____
Practice: _____
Address: _____

_____
Phone: _____

Chiropractor
Name: _____
Practice: _____
Address: _____

_____
Phone: _____

ENT
Name: _____
Practice: _____
Address: _____

_____
Phone: _____

Psychiatrist
Name: _____
Practice: _____
Address: _____

_____
Phone: _____

Pulmonologist
Name: _____
Practice: _____
Address: _____

_____
Phone: _____

Dentist
Name: _____
Practice: _____
Address: _____

_____
Phone: _____

Physical Therapist
Name: _____
Practice: _____
Address: _____

_____
Phone: _____

Cardiologist
Name: _____
Practice: _____
Address: _____

_____
Phone: _____

Psychologist
Name: _____
Practice: _____
Address: _____

_____
Phone: _____

Other
Name: _____
Practice: _____
Address: _____

_____
Phone: _____