WELCOME TO FALLS CHIROPRACTIC AND INJURY!

PATIENT INFORMATION (Most of the information below is required for insurance purposes)

DATE: _____ / _____ / _____

FIRST NAME: _____M.I.:_____ LAST NAME:_____

DATE OF BIRTH: _____/_____/_____ CALLED NAME / NICKNAME: _____

ADDRESS: _____ SUITE OR APT #: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE:(_____) _____ - _____ CELL PHONE:( ) _____ - _____Text ok? Y N

WORK NUMBER:(_____) _____-_____ (for **emergency** use only)

GENDER: (please circle one) MALE FEMALE

MARITAL STATUS:(please circle one) SINGLE MARRIED OTHER: _____

SOCIAL SECURITY #: _____ - _____ - _____

DRIVERS LICENSE #: _____STATE ISSUED_____

WORK STATUS:(please circle one) EMPLOYED FULL-TIME STUDENT PART-TIME STUDENT

EMAIL _____@_____

Referred By: _____

For continuity of care, we would like to send your primary care physician a copy of your initial exam/visit note and x-ray report (if applicable). Please provide your doctor information below:

Doctor Name_____

Practice name: _____

Address/Location name:_____

Phone #:(____) _____-_____ Fax: (_____)_____-_____

_____***(Initial here)*** ***In providing the information above, I acknowledge and consent to the release of this information to my selected primary care physician/office.***

_____ (***Initial Here***) ***In reading this, I acknowledge that I have been informed that a most recent copy of the HIPAA Notice of Privacy Practices is available for me to review or receive a copy if I request one. I understand this office follows all current HIPPA compliance requirements.***

Patient Health Questionnaire (PHQ)

Patient Name_____

HISTORY OF PRESENT ILLNESS (99203: min of 4,99213:1-3)

1. Describe your *CURRENT* symptoms_____
- 2.When did your symptoms start (This *CURRENT* episode) _____

3. How did your symptoms begin? (I.E woke up with it, bent over, gradually etc...) _____

_____

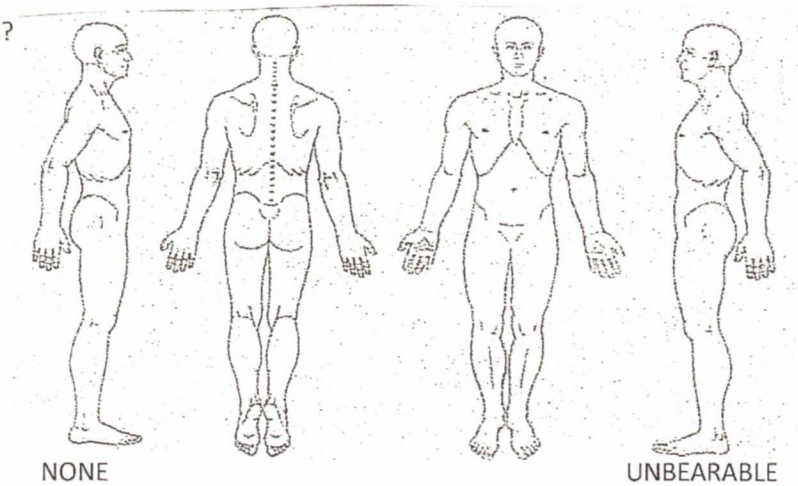
- On the body outline below, please indicate where you have pain or other symptoms: ↓↓↓↓:

- 4. How often do you experience your symptoms?

____ Constantly (76-100% of the day)
____ Frequently (51-75% of the day)
____ Occasionally (26-50% of the day)
____ Intermittently (0-25% of the day)

- 5.What describes the nature of your symptoms:

____ Sharp ____ Shooting ____ Dull ache
____ Burning ____ Numbness ____ Tingling



NONE UNBEARABLE

- 6. Indicate the average intensity of your symptoms: 0 1 2 3 4 5 6 7 8 9 10

7. How much has the pain interfered with your normal activities of daily living, both home and work if applicable:

____ Not at all ____ A little bit ____ Moderately ____ Quite a bit ____ Extremely

- 8. What makes your symptoms WORSE? _____

- 9. What makes your symptoms BETTER? _____

10. What is your occupation? (helps determine mechanics related to issue) _____
____ Full Time ____ Part Time ____ Self Employed ____Unemployed ____Off work ____Other
11. Have you had similar symptoms in the past? ____ YES ____ NO

12. If you have received treatment in the past, who did you see? ____ This office (pprox.. when?) _____
____Medical Doctor ____Physical Therapist ____ Other Chiropractor ____ Other (_____)

13. Have you seen anyone else for this episode of symptoms? ____Medical Doctor ____ Other Chiropractor ____Other

What treatment did you receive and when? _____

What tests have you had for your symptoms and when were they performed? ____XRAY, Date_____

____ CT SCAN, Date _____ ____MRI, Date _____ Other _____

Patient Signature _____ **Date:** _____ / _____ / _____

Patient Name: _____ **Date:** _____/_____/_____

Review of Systems: ***Please check box if applicable, check NO if none please***
(99203: 2 pertinent, 99213: 1 pertinent)

Cardiovascular			No	**Respiratory**			No	**Allergic/Immunologic**			No
	Past	Present			Past	Present			Past	Present	
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								**Ear, Nose and Throat**			No
Jaw Pain				**Eyes**			No		Past	Present	
Irregular Heartbeat					Past	Present		Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary			No	Blurred Vision				Sore Throat			
	Past	Present						Nosebleeds			
Kidney Disease				**Psychiatric**			No	Bleeding Gums			
Burning Urination					Past	Present		Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				**Gastrointestinal**			No
Kidney Stones				Stress					Past	Present	
Lower Side Pain								Gall Bladder Problems			
				Endocrine			No	Bowel Problems			
Neurologic			No		Past	Present		Constipation			
	Past	Present		Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				Menstrual				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				**Hematologic**			No				
Pinched Nerves					Past	Present		**Musculoskeletal**			No
Parkinson's				Hepatitis					Past	Present	
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional			No	Bleeding				Muscle Weakness			
	Past	Present		Fever, Chills				Osteoporosis			
				Sweating				Broken Bones			
Weight Loss/Gain								Joints Replaced			
Low Energy Level											
Difficulty Sleeping											

Past Medical History:

PSFH (99203: 1 pertinent)

List all current prescribed (INCLUDE Dosage and Frequency), over the counter medications and supplements: _____

_____

_____

_____

(Continued next page please)

Height: _____ Weight: _____

Allergies: No Known Allergies ____ Latex ___ Medication (name) _____
Other allergy _____

List all surgeries in your lifetime and approx. year:_____
_____

List all serious illness in your lifetime:_____
_____

List all significant trauma or accidents in your lifetime: _____
_____

Please include approximate dates/year on the above listed

Family Medical History for Heredity and Risk:

Indicate if an immediate family member (parents, grandparents, sibling) currently has or has had any of the following:

__ Diabetes __ Scoliosis __ Lupus __ Cancer Relationship to you?: _____

Social History:

Alcohol Usage ____ frequently ____ occasionally ____ socially ____ never

Tobacco ____ frequently ____ occasionally ____ socially ____ never

Exercise ____ frequently ____ occasionally ____ sporadically

Exercise Type ____ walking frequency/distance _____

____ running frequency/distance _____

____ swimming frequency/laps _____

____ weights type and reps_____

____ classes type and frequency _____

Other concerns or issues you would like to address:

_____

_____

PATIENT SIGNATURE: _____

PATIENT NAME PRINT: _____

Office use ONLY please: Blood Pressure _____/_____ Pulse _____ Temp _____

Automobile Accident Description

Please answer the questions below. If you do not know the answer to any of the questions, do not answer that question.

1. Your vehicle type

❑ Car ❑ Station Wagon
❑ Van ❑ Pickup Truck
❑ Large Truck ❑ Bus
Other_____

2. Your position in vehicle

❑ Driver ❑ Front Passenger
❑ Left Rear Passenger
❑ Right Rear Passenger
Other_____

3. What was your vehicle doing at the time of the accident?

❑ Stopped at intersection ❑ Stopped in traffic ❑ Stopped at light
❑ Making a right turn ❑ Making a left turn ❑ Parking
❑ Proceeding along ❑ Slowing down ❑ Accelerating
Other_____

4. Time/Speed/Damage

Time of accident_____
Your vehicle's speed: _____mph
Their vehicle's speed: _____mph

Damage to your vehicle
❑ Mild ❑ Moderate
❑ Totaled

5. Details of Accident

Visibility at time of accident
❑ Poor ❑ Fair ❑ Good

Who hit who/what?
❑ You hit other vehicle
❑ Other vehicle hit you

You hit...(object)
_____

6. Road conditions

Road conditions at time of accident
❑ Icy ❑ Wet ❑ Sandy ❑ Dark ❑ Clean and dry

Point of impact
❑ Head-On ❑ Left Front ❑ Right Front
❑ Rear-End ❑ Left Rear ❑ Right Rear

7. Body Position, etc.

Did you see the accident coming: **Yes❑❑ No**
Were you braced for the impact? **Yes❑❑ No**
Did you have a seat belt on? **Yes❑❑ No**
Did you have a shoulder harness on? **Yes❑❑ No**

Does your vehicle have headrests? Yes❑❑ No
What was the position of your headrest at the time of the impact?
❑ Even with top of head ❑ Even with bottom of head ❑ Middle of neck
What was the direction of your head at the time of the impact?
❑ Facing straight forward ❑ Turned to the right ❑ Turned to the left

Did driver side air bags deploy? **Yes❑❑ No** Did passenger side airbags deploy? **Yes❑❑ No** Did side airbags deploy? **Yes❑❑ No**

8. Additional accident information

In the case of a motor vehicle accident, enter any additional information here that is not covered by the above check offs.

9. During the accident:

Did your body strike the inside of your vehicle? **Yes❑❑ No**
If yes, describe:_____
Did you lose consciousness during the injury? **Yes❑❑ No**
If yes, for how long? _____
Your vehicle's estimated damage?_____
Damage to their vehicle: ❑ Mild ❑ Moderate ❑ Totaled
Did police show up at the scene? **Yes❑❑ No**
Was an accident report filled out? **Yes❑❑ No**

10. After the accident:

Check off your symptoms right after and a few days following:

❑ Headache	❑ Dizziness	❑ Mid back pain	❑ Cold hands
❑ Neck pain	❑ Nausea	❑ Low back pain	❑ Cold feet
❑ Neck stiffness	❑ Confusion	❑ Nervousness	❑ Diarrhea
❑ Fainting	❑ Fatigue	❑ Loss of taste	❑ Depression
❑ Ringing in ears	❑ Tension	❑ Toe numbness	❑ Anxious
❑ Loss of smell	❑ Irritability	❑ Constipation	❑ Chest Pain
❑ Pain behind eyes	❑ Shortness of breath	❑ Sleeping problems	

Others:_____

11. Emergency Room?

Where did you go after the accident?
❑ Home ❑ Work ❑ Hospital ER ❑ Private Doctor

How did you get there?
❑ Drove self ❑ Somebody else ❑ Ambulance ❑ Police

Were X-rays done? Yes❑❑ No **Was lab work done?** Yes❑❑ No
Body parts X-rayed?_____
What lab work?_____
The X-rays revealed:_____
Treatments: ❑ Cervical Collar ❑ Ice **Other:** _____
Medications:_____
Follow-up instructions:_____
_____

12. Treatment History:

Fill in any other doctor(s) seen prior to your first visit to this office

1. Dr. _____ First visit date: ____/____/____
Specialty:_____ X-rays done? **Yes❑❑ No**
Types of treatments received:_____
How many treatments received? ____ Currently treating? **Yes❑❑ No**
Did treatments benefit you? **Yes❑❑ No**
Last visit date: ____/____/____

2. Dr. _____ First visit date: ____/____/____
Types of treatments received:_____
How many treatments received? ____ Currently treating: **Yes❑❑ No**
Did treatments benefit you? **Yes❑❑ No**
Last visit date: ____/____/____

Patient Sign & Date:_____ **Date:**_____

FALLS CHIROPRACTIC AND INJURY

Please list the things that you cannot due because of your accident:

1) _____

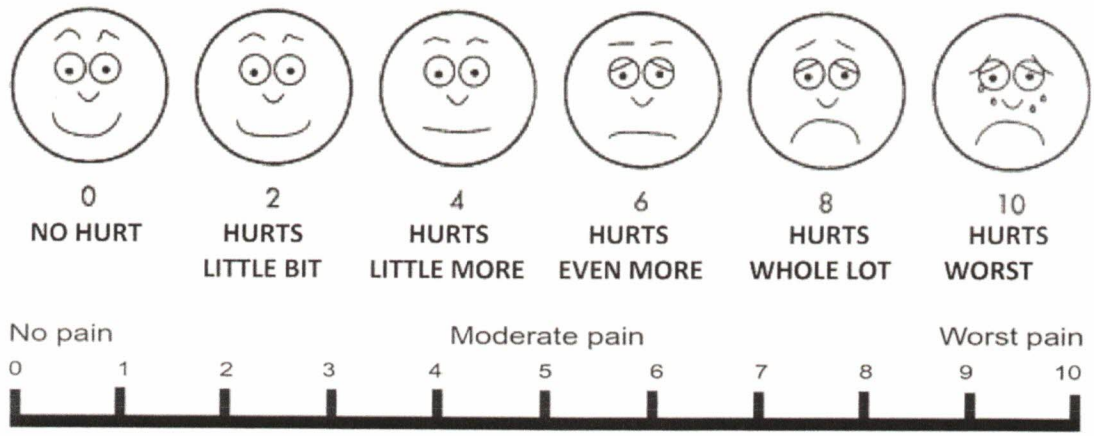
2) _____

3) _____

4) _____

5) _____

Please rate you pain today using the scale below:



Name of the patient: _____

Sign: _____

Date: _____

Doctor Signature_____

INFORMED CONSENT FORM

PATIENT NAME: _____ DATE: _____

To the patient: Please read this entire document prior to signing it. It is very important that you understand the information contained in this document. If anything is unclear, please ask questions before you sign.

The nature of the chiropractic adjustment
The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment
As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

-spinal manipulative therapy	-palpation	-range of motion testing	-orthopedic testing	-vital signs
-muscle strength testing	-postural analysis	-neurological testing	-myofascial release	
-hot/cold therapy	-electrical stimulation	-radiographic studies	-mechanical traction	

The material risks inherent in chiropractic adjustment.
As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.
Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.
Other treatment options for your condition may include:
- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.
Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTOOD THE ABOVE.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

_____	Richard A. Laviano D.C.	Natalia Lopez Vazquez D.C.
Patient Name Print	**Doctor Name Print**	**Doctor Name Print**
_____	_____	_____
Patient/Guardian Signature	**Doctor Signature**	**Doctor Signature**
_____	_____	_____
Date	**Date**	**Date**

INSURANCE INFORMATION

THIRD PARTY INSURANCE INFORMATION:

Insurance Company: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Accident: _____ Claim #: _____

Adjuster's Name: _____ Phone #: _____

Fax #: _____

PERSONAL AUTO INSURANCE/MEDPAY: ( ) YES ( ) NO

Insurance Company: _____

Address: _____

City: _____ State:_____ Zip Code: _____

Claim #: _____ Policy #:_____

Adjuster's Name: _____ Phone #: _____

Fax Number: _____

DO YOU HAVE AN ATTORNEY FOR THIS CASE? ( ) Si ( ) No

Attorney's Name:_____ Phone #: _____ Fax #: _____

PERSONAL HEALTH INSURANCE:

( ) YES, I want my health ins to be billed for this accident ( ) NO/DECLINE

Patient's Health Insurance: _____

Insured's name (if different than patient): _____

Member ID: _____ Group # _____

Note: COPAYS ARE REQUIRED TO BE PAID AT THE TIME OF SERVICE. BECAUSE OF SOME INSURANCE SPECIAL BILLING REQUIREMENTS (PRIOR AUTHORIZATIOSNS, FILING LIMITS, ETC) WE MAY NOT BE ABLE TO BILL RETROACTIVE CLAIMS.

FALLS CHIROPRACTIC AND INJURY:

To any insurance company with coverage applicable to my claim(s) and to any attorney representing me:

ASSIGNMENT OF BENEFITS

IN CONSIDERATION of the willingness of Falls Chiropractic and Injury to treat me on credit without demand for payment at the time services are rendered, I hereby agree and stipulate as follows:

I irrevocably assign to Falls Chiropractic and Injury any proceeds or compensation that I am or may become entitled to receive as a result of injuries that occurred on _____ (date of the accident) to the extent of the chiropractic services rendered. I make this agreement without prejudice to any rights I may have to prosecute legal claims against any party who may be liable for my injuries, but I hereby authorize and instruct you to pay directly to Falls Chiropractic and Injury , from any disability benefits, medical payments benefits, liability benefits, health and accident benefits, workers compensation benefits, judgments, settlements, or proceeds of any kind that would otherwise be payable to me, such sums as are due to Falls Chiropractic and Injury for its services rendered.

I appoint Falls Chiropractic and Injury as my attorney in fact to affix my name as an endorsement upon the reverse of any check or draft upon which I am a named payee and to deposit said check or draft and apply the proceeds to any unpaid balance I may have with Falls Chiropractic and Injury.

I authorize Falls Chiropractic and Injury to release to any insurer with applicable coverage or to my attorney or successor attorney any information regarding my injuries, prior medical history, or treatment as may be necessary to facilitate collection of proceeds under this assignment.

I acknowledge that I remain personally liable for the total amount due to Falls Chiropractic and Injury for services rendered, including any balance remaining after the application of insurance payments and settlement or judgment proceeds. If Falls Chiropractic and Injury is required to take legal action against me to recover any unpaid balance on my account, I agree to reimburse Falls Chiropractic and Injury for its costs of recovery, including reasonable attorney's fees.

I further agree this assignment of benefits (AOB) cannot be revoked and the right to receive payment cannot be transferred to any other party or re-asserted by me in any way.

_____

Patient Signature

_____

Date

_____

Witness

NOTICE OF LIEN

Pursuant to N.C.G.S. 44-49 and 44-50, Falls Chiropractic and Injury hereby asserts and gives notice of a lien upon any sums recovered in damages for personal injury in any civil action and also upon all funds paid to the above-named patient in compensation for or settlement of injuries sustained, whether in litigation or otherwise.

Falls Chiropractic and Injury hereby requests that if its claim is not paid in full from the foregoing proceeds, a full disclosure and accounting of proceeds be provided in conformity with N.C.G.S. 44-50.1. Falls Chiropractic and Injury agrees to be bound by any confidentiality agreements regarding the contents of the accounting.

By: _____ Date: _____

Falls Chiropractic and InjuryAuto/Personal Injury Office Policy
Richard A Laviano D. C

Fall Chiropractic and Injury will accept you as an auto/personal injury/worker's comp patient based on our clinical examination and our belief that chiropractic care will be an effective treatment of your injuries.

Your responsibility to this office will be to follow the doctor recommendations for care and to provide the appropriate financial information so that payment for services can be billed on your behalf and payment received in a timely manner.

The account balance is always the responsibility of you, the patient. Falls Chiropractic and Injury does extend credit during treatment and up to 90 days after being released from care for the injury. You may still opt to continue care with us if you choose. After 90 days, if the account is not paid via the billing parties you have provided, you will be expected to pay the account in full or make acceptable monthly payment arrangements. After 30 days of release from care if not paid in full your account will be assessed a 1.5% monthly finance charge. If the insurance or attorney does not pay this charge it will be your out of pocket responsibility. **We WILL NOT reduce or negotiate rates of our charges at any time**. Our charges are reasonable and customary.

We can bill the liable party insurance, your Medpay with your auto policy and/or health insurance. You will be given a sheet to provide this information. Any overpayments will be refunded to you unless you notify us to return to the issuing party. You are responsible for determining if you need to have them reimbursed or may keep the overpayments.

Following the completion of your treatment, we will notify the liable party/parties and forward all bills and medical records directly to them. In some cases, you will be asked to return for a permanent disability/injury exam in 4-6 weeks and records/bills will be held until that is completed. Please advise us in advance if you would like a copy of your medical records for your personal use as it is easiest to make multiple copies at one time.

Our cancellation/reschedule of appointment policy is a 4-hour notice. The fee for short notice or missed appointments is $50 and may not be covered by the liable party or health insurance. We do have a date and time stamped message system to allow for timely cancellations.

_____ _____ / _____ / _____

Patient Signature Date

_____ _____

Patient Printed Name Witness Signature

Election Not to File Health Insurance Claims (Personal Injury/Accident)

The chiropractor(s) at Falls Chiropractic and Injury are participating ("in-network") providers for your health benefit plan. As participating providers, we are obligated to file claims for reimbursement with your plan for all covered services provided to you UNLESS you instruct us in writing not to file.

You have indicated that rather than using your own health insurance, you wish to consider seeking payment from other third-party payors such as your auto insurance Medpay benefits or the at-fault driver's liability insurance. To help you make an informed decision, please carefully review the following information.

If you elect NOT to file claims on your health insurance:

1. The clinic will rely on your decision and extend credit to you for the cost of care based on the assumption that your bill will be paid by sources other than your health insurance. You will be required to assign to the clinic the right to receive monies paid by liability insurers, medical payments insurers or other third-party payors to the extent necessary to satisfy your bill.
2. You will not be required to pay co-payments/co-insurance and/or deductibles that would normally be required by your health benefit plan.
3. The cost of your treatment will be billed at the clinic's usual rates rather than the discounted rates that routinely apply to services covered by your health benefit plan.
4. If the combined payments received from other sources do not fully satisfy your bill, you may be personally liable for any unpaid balance.
5. None of the charges for your treatment will be applied towards satisfying the annual deductibles associated with your health benefit plan.

If you elect TO file claims on your health insurance:

1. Your health insurance should pay the cost of *covered* services associated with this accident/injury EXCEPT FOR copayments, co-insurance and/or deductibles, which you will be expected to pay directly to the clinic at the time services are rendered.
2. You will be responsible for paying to the clinic the cost of any *non-covered* services you elect to receive, and your payment will be due at the time services are rendered.
3. If your health benefit plan initially pays the clinic for your treatment and later determines that it is not legally responsible for payment, the plan administrator may require the clinic to refund to the plan all or part of the payments received. If that happens, you will become responsible for reimbursing the clinic the amount it was required to refund.
4. Your health benefit plan requires the clinic to submit claims in a timely fashion and while timely filing requirements vary, most plans require claims to be filed within 3-6 months from date of service. If your action or inaction causes a claim to be submitted late, the claim could be denied, and you would be responsible for paying this clinic for those services which were denied.

Election not to file health insurance claims:

1. By my signature below, I attest that I have read and understand the above information regarding the options available to me and have been given an opportunity to ask questions and to have those questions answered.
2. I hereby instruct the clinic not to file claims on my health insurance for services associated with this accident/injury, and I authorize the clinic to seek payment from, and send my treatment records to, other third-party payors who are potential sources of payment.
3. I understand that the clinic is relying on my decision not to file health insurance claims, and that with regards to claims related to this accident/injury, this decision is irrevocable.
4. I understand that no subsequent action on my part shall impair the clinic's right to bill and receive payments from third-party payors; subject only to any contractual obligation the clinic may have to my health benefit plan.

_____	_____
Printed Name of Patient	**Printed** Clinic Representative
_____	_____
Signature of Patient (or parent/legal guardian)	Signature of Clinic Representative
_____	_____
Date	Date

A complete copy of this executed agreement must be maintained in the patient's health care record, and a copy must be provided to the patient.

FALLS

Chiropractic and Injury

6009 Falls Of Neuse Rd, Raleigh, NC 27609

PH: (919) 876-9472 FAX: (919) 876-9478

REQUEST FOR RECORDS AND/OR IMAGES

DATE:_____ / _____ / _____

I hereby authorize:
Doctor or Facility name: _____
Address _____

Phone #:( )_____-_____ Fax #: ( ) _____ - _____

To release my medical records, radiology reports and/or images to Falls Chiropractic & Injury.
Please release the following health information via fax unless otherwise indicated below:

_____ X-Ray Films **with** Report (please fax report and then mail or courier images CD)
_____ **MRI Scan CD with** report (please fax report and then mail or courier images CD)
_____ **H&P, ov notes, labs, radiology reports**
_____ All ED or visit records in regards to personal injury or MVC on _____
Other _____

Purpose of release is sharing with another healthcare provider unless indicated:
_____

Date(s) of Service: _____

Patient Name (printed): _____

Patient date of birth: ____/_____/_____ Patient SS#: XXX-XX-_____

PATIENT SIGNATURE: X_____

PLEASE FAX ALL RECORDS TO **(919) 876-9478**.
IF IMAGES ARE REQUESTED, PLEASE SEND THOSE BY MAIL.

IF YOU CANNOT COMPLY WITH THIS REQUEST PLEASE NOTIFY US IMMEDIATELY. THANK YOU!