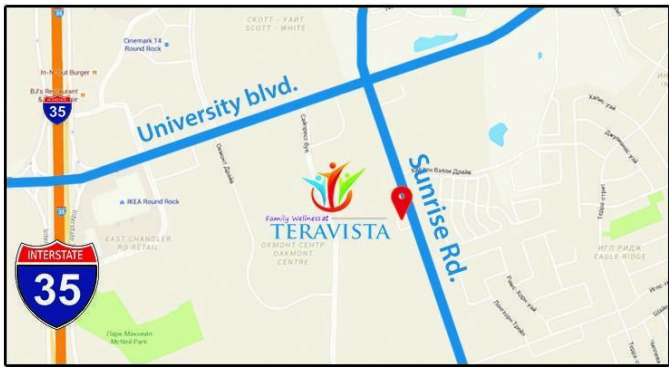
Family Wellness at TERAVISTA



REFERRAL FOR CHIROPRACTIC CARE

PATIENT INFORMATION

Patient Name: _____ DOB: _____ □Male □Female

Primary #: _____ Secondary #: _____

Zip Code: _____ Insurance Provider: _____ Member #: _____

Patient Signature (if releasing records): _____

□*Please release my records from the referring provider to Family Wellness at Teravista.*

PATIENT SYMPTOMS

Patient Complaint: _____

_____

Condition is due to: □ Metabolic Syndrome □ Sports Injury □ TMJD □ Other □ Unknown

Diagnoses: _____

Date of Onset or Injury: _____

□ Patient Will Call to Schedule □Call Patient to Schedule □ Evaluate & Treat

REFERRING PHYSICIAN

Referring Physician Name: _____

Staff Contact:_____

Office Address: _____

Office Phone: _____ Office Fax: _____

Referring Physician Signature: _____ Date: _____

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