

Ash Chiropractic & Wellness

When it comes to your health, we believe medical doctors and Chiropractors should work together for YOUR benefit. I give you permission to inform my personal medical doctor of my condition, treatment and expected / actual response to care at this office.

Signature of Patient or Guardian

Date

Please print your name

Doctor's name _____

Address _____

Phone _____

Type of doctor (circle) Primary Care Orthopedist Neurologist Neurosurgeon

Doctor's name _____

Address _____

Phone _____

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Address _____

Phone _____

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