Borges Chiropractic

Patient Record of Disclosures

Please fill out completely

Patient Name: ____________________ Date of Birth: ____________________

Who may we release medical information to:

Name:____________________________ Relationship to you:________________

Name:____________________________ Relationship to you:________________

Name:____________________________ Relationship to you:________________

I wish to be contacted in the following manner
(check all that apply)

☐ **Home Telephone**____
☐ Okay to leave message with detailed information
☐ Leave message with call back number and name of Borges Chiropractic only

☐ **Work Telephone**____
☐ Okay to leave message with detailed information
☐ Leave message with call back number and name of Borges Chiropractic only

☐ **Cellular Phone**____
☐ Okay to leave message with detailed information
☐ Leave message with call back number and name of Borges Chiropractic only

☐ **Email Address**____
☐ Okay to send information regarding insurance

☐ **Other**____

Signature____________________________________Date______