

1436 S Edgewater Circle
Nampa, ID 83686
Phone: 208-463-9600
Fax: 208-461-3156



To better coordinate your treatment, please list the professionals you have consulted regarding your present symptoms. Please be sure to list your primary physician and family dentist. Please initial if you want us to send them a report from your visit.

Initial _____ **FAMILY PHYSICIAN**
Name _____
Address _____
Phone _____

Initial _____ **DENTIST**
Name _____
Address _____
Phone _____

Initial _____ **CHIROPRACTOR**
Name _____
Address _____
Phone _____

Initial _____ **PHYSICAL THERAPIST**
Name _____
Address _____
Phone _____

Initial _____ **ENT**
Name _____
Address _____
Phone _____

Initial _____ **CARDIOLOGIST**
Name _____
Address _____
Phone _____

Initial _____ **ALLERGIST**
Name _____
Address _____
Phone _____

Initial _____ **NEUROLOGIST**
Name _____
Address _____
Phone _____

Initial _____ **PSYCHIATRIST**
Name _____
Address _____
Phone _____

Initial _____ **PSYCHOLOGIST**
Name _____
Address _____
Phone _____

Initial _____ **PULMONOLOGIST**
Name _____
Address _____
Phone _____

Initial _____ **OTHER**
Name _____
Address _____
Phone _____

- I understand and agree to have the indicated professionals I have listed above be sent initial information and ongoing updates regarding my diagnoses and treatment.
- I do not wish to have my records sent at this time.

I certify that the above information is correct to the best of my knowledge.

PATIENT/GUARDIAN SIGNATURE _____

DATE _____