PATIENT NAME:_____ DATE:____/____/____

DATE OF BIRTH:____/____/____

PAST TREATMENT HISTORY

PLEASE LIST ALL DOCTORS/HEALTH PRACTITIONERS YOU HAVE SEEN IN THE PAST YEAR:

	DATE	DOCTOR NAME/LOCATION	TYPE OF DOCTOR	REASON
1.				
2.				
3.				
4.				

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

	NAME	DOSAGE	REASON	PRESCRIBED BY
1.				
2.				
3.				
4.				

PLEASE CIRCLE ANY OF THE FOLLOWING TESTS THAT YOU HAVE EVER HAD DONE:

MRI: _____

CAT SCAN: _____

EKG: _____

EMG: _____

BLOOD WORK: _____

X-RAYS: _____

ULTRASOUND: _____

BONE SCAN: _____

OTHER: _____

UNITED
SPINE
CENTRE

Dr. John Feeney
Dr. Sean Feeney
Dr. Nicole Stoessel
Dr. James Sheehan
Dr. Tom Kneavel

835 Pulaski Highway (Route 40) - Bear, Delaware 19701 - (302) 328-0200 - Fax: (302) 328-3289

Date: ____/____/____

Attention: _____

Patient name: _____

I hereby authorize the release of my x-rays / records, and request that they be transferred to:

United Spine Centre
835 Pulaski Hwy.
Bear, DE 19701

_____

Patient signature