So that the doctor may provide you with the highest quality of care, please list any medications/vitamins/or mineral supplements that you are currently taking. The doctor keeps this in consideration throughout your care and uses a professional opinion to let you know if she thinks you should be taking more or less dosage of a supplement.

Medication/Supplement	Dosage	Times/Daily

As a patient in our office, our primary goal is to help you reach a state of wellness and health. In order to do so, we ask for your permission to contact your primary care physician or another doctor if deemed necessary, to state the conditions in which we are treating you for. This is so they may know and incorporate your treatment into any diagnosis or treatment they provide to you. By involving your primary doctor in your care, we allow for comprehensive treatment and thus a higher level of wellness for you.

Primary Care Physician ______________________ Office Location__________

Other Preferred Doctor ______________________ Location ________________

I, ____________________________, authorize KB Chiropractic Center to correspond with the above-stated doctor(s) regarding my diagnosis, treatment, and health conditions.

Signature: ________________________________ Date: ________________