

# Healthcare Provider Contacts

Please list your healthcare providers (e.g., physician, dentist, chiropractor, psychotherapist, etc.) and let us know if we may send information about acupuncture and let them know you're receiving care from us.

Name: \_\_\_\_\_

Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Okay to contact?  Yes  No

Name: \_\_\_\_\_

Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Okay to contact?  Yes  No

Name: \_\_\_\_\_

Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Okay to contact?  Yes  No

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Signature

Name: \_\_\_\_\_

Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Okay to contact?  Yes  No

Name: \_\_\_\_\_

Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Okay to contact?  Yes  No

Name: \_\_\_\_\_

Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Okay to contact?  Yes  No

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Date