DIAGNOSTIC IMAGING CONSULTANTS

A. Scott Thorpe, DC, DACBR, Rudy N. Heiser, DC, MS, DACBR,

Terry Sandman, DC, MPH, DACBR

SPINAL LOGIC CHIROPRACTIC DR. MIKE WOOLARD

1300 E MAIN STREET

DANVILLE, IN 46122 E-mail: [drdreamers@aol.com](mailto:drdreamers@aol.com)

PH: 317-745-5111 FAX: 317-745-2435

# \*\*Please print and complete form for each patient and include with films

# 

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_ Sex \_\_\_M\_\_\_F

# Films being sent (type of study)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# NUMBER OF IMAGES SENT: 6 5 4 3 2 1

**DATE TAKEN:\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Medical History:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# 35490

# BILL DR.

**I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_hereby authorize Spinal Logic Chiropractic to release my Xrays to Diagnostic Imaging for review and report of any and all medical diagnosis. I understand my information will not be shared with any other entity without my permission.**

**Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**5136 Central Ave., St. Petersburg, FL 33707**

**Phone: 727-579-2500 Fax 727-579-1060**