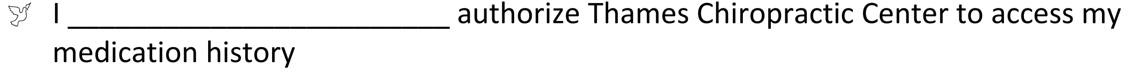
Please provide the following so that we may communicate with your other health care providers effectively. This information will help with inter-provider communication and patient safety.
Please sign and check below:

Name: ____

□ There are no changes since your last visit



I ___________________________ authorize Thames Chiropractic Center to access my medication history

Current Medications and Dosage:

Name	Dosage	x/day

ALLERGIES TO MEDICATIONS