lazarspinalcare pc

We Listen. We Care. We Get Results.

New Patient Information
TRANSFER

Today's Date: ___________________

Name*: ______________________________ DOB: ______________________________

Phone: ______________________________ Email: ______________________________

Date of Request: ______________________________

Previous Doctor or Facility: ______________________________

Phone: ______________________________

Listing from previous doctor: ______________________________

Date of last visit: ______________________________ Date of last x-rays: ______________________________

Was there any trauma after last x-ray?: ☐ Yes ☐ No

If yes, please describe with date and details:

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Date of last exam: ______________________________

Was there any trauma after last exam?: ☐ Yes ☐ No

If yes, please describe with date and details:

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Current schedule: __________________ visits per _____________(week / month)

Authorize for release of Medical Records:

I hereby give permission for ______________________________(facility or doctor name) to release the following information (check all that apply):

☐ Examinations

☐ X-rays

☐ X-ray listings

to Lazar Spinal Care, P.C. Please email information to care@lazarspinalcare.com, fax to (734) 661-4828, or mail to 203 S. Zeeb Rd. Suite 106 Ann Arbor, MI 48103 so it arrives ***no later than 24 hours prior to the new patient visit date listed above.***

Signature: ______________________________ **Date:** ______________________________