



**Confirmation Of Care Of Western Medical Physician**

Dear Doctor/Patient:

In an effort to update our records and provide the highest standard of care to possible we are requesting you complete the following documentation. It will become part of your file in our office and remain confidential at all times.

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**Patient please complete the following prior to physician office visit:**

Patient Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Signature Authorizing Release Of Information: \_\_\_\_\_

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**Physicians please complete the following and return to patient or send medical information to:**

\_\_\_\_\_  
Name of Physician

\_\_\_\_\_  
Name of Clinic/Hospital

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_ Height                      \_\_\_\_\_ Weight:                      \_\_\_\_\_ Blood Pressure:

\_\_\_\_\_  
Physician Signature

**Susquehanna Acupuncture & Healing Arts Center  
44 West Market Street  
Marietta, PA 17547**

**Thank you, for your prompt completion of this document and return to our office. Your assistance is greatly appreciated. If you have any questions please call (717)-426-3166 we will be happy to help in any way.**