Gordon D. Elder, DC, PA dba Blair Chiropractic Clinic

Request for Alternative Communications

Patient Name: _____

Date of Birth: _____ Chart ID: _____

Address: _____

Request Date: _____

Please check the alternative means of contacting you and provide the necessary information below:

- ❑ Email: _____
- ❑ Cell Phone: _____
- ❑ Home Phone: _____
- ❑ Work Phone: _____

Please specify your alternative method of handling payments:

- ❑ Send statements and other medical documentation to the address listed above.
- ❑ Send statements and other medical documentation to the alternate address listed below:

  _____

  _____

Signature of Patient: _____ Date: _____