

REQUEST FOR DISABILITY FORM

1. ALL PATIENTS fill out the following:

Today's Date: _____

Patient Name: _____

Patient D.O.B. _____

Home Address: _____

Phone No. (Home): _____ (Work): _____

Physician treating patient's disability: _____

Please allow five (5) business days for completion of forms. Once forms have been completed the patient will be contacted.

When the forms are ready, you will be called to pick them up at the office. If you prefer the forms to be faxed, please provide a fax number: _____

Please sign below: (Release of medical/records information)

X _____

Patient Signature