Patient's Name: ______________________________ DOB: __________

Patient Phone: ____

Physician Name: ____

Medical Diagnosis: ____

Frequency: ☐ Eval and Treat OR ______/wk. x ______ wks.

Surgical Procedures/Instructions:

_______________________________________ Physician's Signature

__________ Date

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Our Clinic Locations

I-4

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COLLEGE PARK
1615 Edgewater Dr
Suite 180
Orlando, FL 32804
Phone (407) 601-6412
Fax (407) 601-6773

ALTAMONTE SPRINGS
745 Orienta Ave
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Altamonte Springs, FL 32701
Phone (407) 332-7816
Fax (407) 332-6361

WATERFORD LAKES
12780 Waterford Lakes Pkwy
Suite 115
Orlando, FL 32828
Phone (407) 207-7188
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