

**Noreen Long, DC**  
*Acupuncture & Chiropractic in Black Mountain*  
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Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Primary Care Physician \_\_\_\_\_

Clinic Name \_\_\_\_\_ Specialty \_\_\_\_\_

Clinic Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Tel. No. (\_\_\_\_\_) \_\_\_\_\_

By signing below, I authorize Dr. Long to contact the above clinic/physician and share information about Dr. Long's diagnosis and treatment. I understand that Dr. Long will not charge me for this service.

\_\_\_\_\_  
Signature of patient Date \_\_\_\_/\_\_\_\_/\_\_\_\_