REPORT OF MEDICAL TREATMENT

Mail, fax, hand deliver or email to: medical@kathleendaylaw.com
Law Office of Kathleen L. Day 1001 Santa Fe Corpus Christi, Texas 78404
Business: (361) 888-4342 Fax: (361) 883-3433

Name: **Last 4 of SSN:**

Current Address: **Current Phone #:**

1. Name of Doctor/Hospital/Clinic:
   Address: First Visit: ____________
   Phone: Last Visit:
   Reason for visit: Next Visit: ☐ None
   Treatment received:

Test Type	Date	Test Type	Date
☐ Lab work	________	☐ MRI of ________	________
☐ EKG	________	☐ XRAY of ________	________

2. Name of Doctor/Hospital/Clinic: ____________
   Address: ____________ First Visit: ____________
   Phone: ____________ Last Visit: ____________
   Reason for visit: ____________ Next Visit: ____________ ☐ None
   Treatment received: ____________

Test Type	Date	Test Type	Date
☐ Lab work	________	☐ MRI of ________	________
☐ EKG	________	☐ XRAY of ________	________

3. Name of Doctor/Hospital/Clinic: ____________
   Address: ____________ First Visit: ____________
   Phone: ____________ Last Visit: ____________
   Reason for visit: ____________ Next Visit: ____________ ☐ None
   Treatment received: ____________

Test Type	Date	Test Type	Date
☐ Lab work	________	☐ MRI of ________	________
☐ EKG	________	☐ XRAY of ________	________

4. Name of Doctor/Hospital/Clinic: ____________
   Address: ____________ First Visit: ____________
   Phone: ____________ Last Visit: ____________
   Reason for visit: ____________ Next Visit: ____________ ☐ None
   Treatment received: ____________

Test Type	Date	Test Type	Date
☐ Lab work	________	☐ MRI of ________	________
☐ EKG	________	☐ XRAY of ________	________

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Name: ______________________________ **SSN:** ______________________________

NAME OF MEDICATION	PRESCRIBING DOCTOR	REASON FOR TAKING	SIDE EFFECTS