

## Patient Brochure Order Form

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Phone (Area Code) \_\_\_\_\_ Fax (Area Code) \_\_\_\_\_  
Email \_\_\_\_\_ Clinic name \_\_\_\_\_

### Please provide the following information in electronic format:

- Clinic name**
- Your name and title**
- Description of clinic and practice**—In the body of an email, or attached in email as a Microsoft Word document.
- Portrait**—JPEG or TIFF, at least 2" wide at 300 dpi resolution. Black and white or color, but we will print your photo in black and white. Do not include in another document or Word file.  
If you need help, call us at: 888-776-5489.
- A brief biography**—Include the year and college where you received your D.C. degree
- Patient testimonials**—In a Microsoft Word document

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