Patient Testimonial Form

We would love to hear from you about your experience with our office.
Help us tell others by providing us with a description of your experience.

Name:_____ City: _____

Your Physician: _____ Email: _____

Your name will appear as “First, Last Initial” on any materials we include it in. We respect your right to privacy, and we will not distribute any personal information to any third party.

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Consent & Release Terms and Conditions:
Through my signature below, I hereby authorize my physician & Choice Medical Group to reproduce my testimonial, in full or in part, in his marketing materials and website. I understand my testimonial may be edited for clarity and/or conciseness.
I have voluntarily provided the health information above. The information stated above is accurate and true to the best of my knowledge.

_____ _____

Signed Date

☐ I will provide a photo.

☐ I give permission for a photo to be taken.

☐ No photo – testimonial only.

Here are some questions that can guide you:

- Please describe the condition you came in for /health prior to receiving care at our office.
- Please explain how this condition affected your daily life or performance.
- Please describe any previous methods of health care (medications, therapies, surgeries, etc) What were the results?
- How long was it before you noticed improvements in your condition?
- What can you do now that you could not do before?
- Share your experience about our staff and the care that you received.
- What amazed you the most?

Email to emcgiffin@choicemg.com or Fax to (760) 242-3927