Welcome Back!

Fill out form completely to avoid delays in checking you in

Today's Date:_______/______/_____ Check-In Time: ___________

Patient Name: ____ Date of Birth:____________

Address: _________________________Apartment/Unit #_________City ____________ Zip Code ________

Phone Number: ___________________________ Email: _______________________________

Drug Allergies: ____

New Insurance? YES NO

Pharmacy Name & Phone Number: _______________________________________

- Is this for a work-related injury? YES NO
- Is this visit for a motor vehicle accident? YES NO
- Here for COVID Testing? YES NO
- Have you been exposed to anyone COVID positive? YES NO
- Will COVID testing be used for travel? YES NO
- Will COVID testing be used for surgery? YES NO

- Are you currently experiencing any of the following symptoms? (Check all that apply) __Cough __Fever __Body Aches __Nausea/Vomiting __Loss of Smell __Shortness of breath __Headache __Diarrhea __Fatigue __Sore Throat

Reason for today's visit: ____

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