## Walk-In Clinic Patient Information Form

First Name: Last Name:
Date of Birth:/ MM/DD/YY
Address:
Health Care Number:
1. Are you a new patient? Yes No
2. Do you have any allergies? Yes No
If yes, please list:
3. Are you taking any medicine? Yes No
If yes, please list:
Emergency Contact:
Name: Relationship:
Phone:
Signature: