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: _____