2370 Hillcrest Rd, STE M

Phone: 251-459-6200

Fax: 251-923-4244

New Patient Visit Reason:

Patient Name: _____ **Phone number:** _____

Address: _____

Social Security Number: _____-_____-_____ **Date of Birth:** _____

Email: _____ **How did you hear about us?** _____

Emergency Contact: _____ **Emergency contact phone:** _____

What pharmacy will you be using today: _____

Give brief reason for your visit today and list symptoms and duration:

_____

_____

B/P_____ **Pulse** _____**Resp:** _____**Temp:**_____**O2%** _____**Ht:** _____ **Wt:** _____

List of Medication	**Reason for taking**	**List ANY Allergies**
_____		_____
_____		_____
_____		_____

Do you do any of the following	**List any surgeries**	**Year**
Smoke Yes NO how much _____**day** _____**week**	_____	_____
Drink Yes NO how much _____**day** _____**week**	_____	_____
E-Cig Yes NO how much _____**day** _____**week**	_____	_____
Drugs Yes NO what kind_____**daily**____**weekly**____	_____	_____
Tobacco Yes NO _____**daily**_____**weekly**	_____	_____
Do you exercise regularly Yes NO how much per week? _____	_____	_____

I certify that the above information is correct to the best of my knowledge. I will not hold the doctor/provider or any members of his/her staff responsible for any errors or omissions that I may have make in the completion of this form

Patient or Guardian Signature:_____**Date:**_____