Waiting Room

Exam Room

Prescription Pad

For _____ Date _____

℞ Address _____

Refill _____ Times

_____ M.D.

For _____ Date _____

℞ Address _____

Refill _____ Times

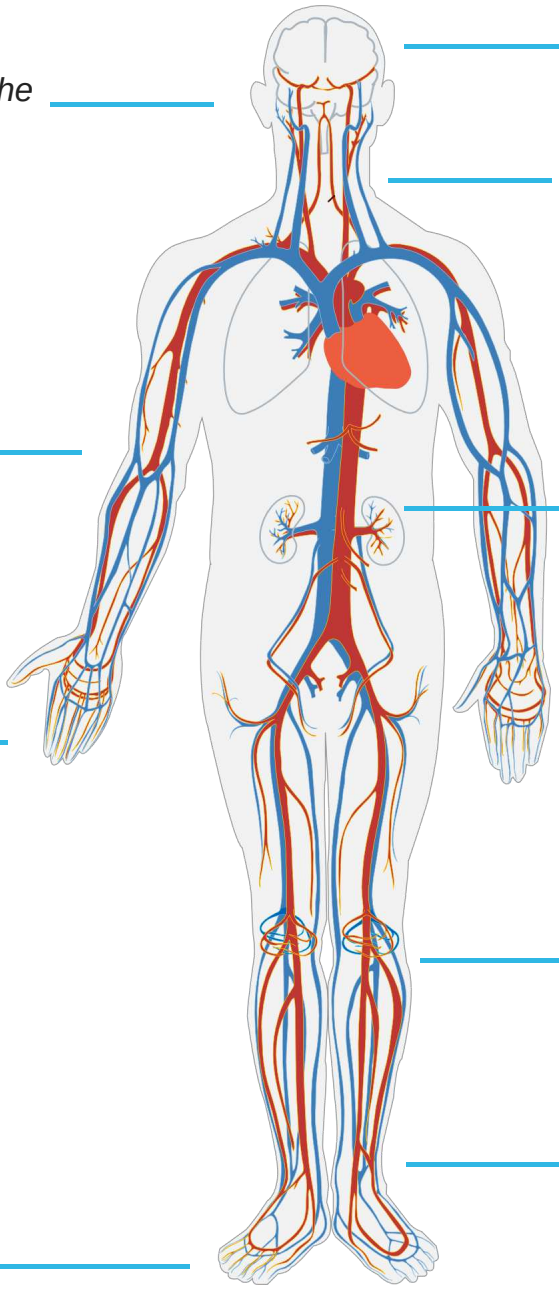
_____ M.D.

Patient Information

Patient Name _____ **DOB** _____

Reason for visit _____

Weight _____ **Height** _____ **BP** _____



Headache

Ear Ache

Sore Throat

Broken or Sprained Arm

Stomach Ache

Broken Finger

Broken or Sprained Leg

Sprained Ankle

Broken Toe

Print and Cut For Your Office

Hospital ID

Official Photo

Name

Specialty

Signature

Hospital ID

Official Photo

Name

Specialty

Signature

Patient Satisfaction Card

Did You Like Your Doctor? YES NO

Do You Feel Better? YES NO

Will You Visit This Doctor Again? YES NO