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 ________

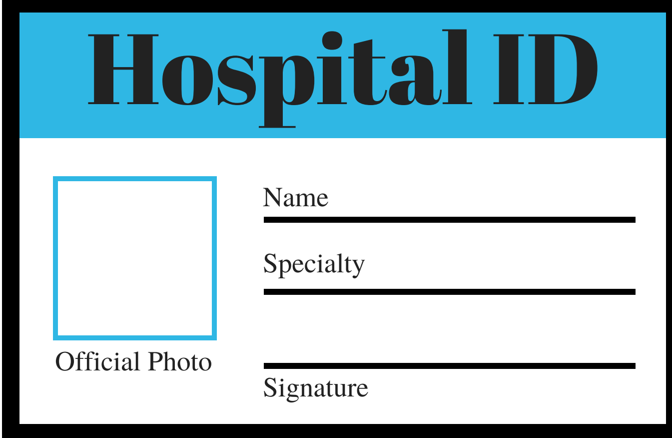
Broken Finger ________

Broken or Sprained Leg ________

Sprained Ankle ________

Broken Toe ________

Print and Cut For Your Office



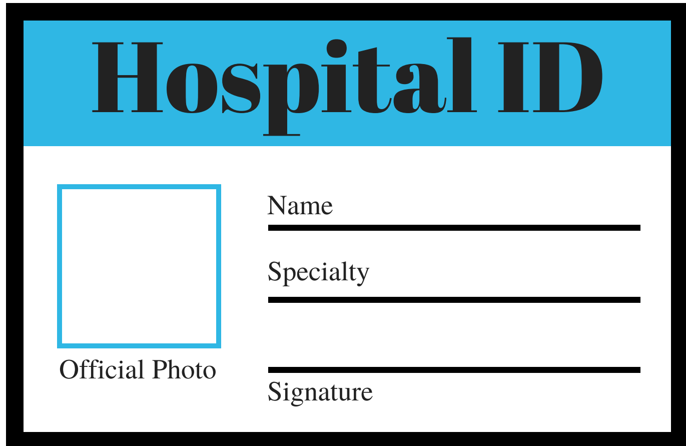
Hospital ID

Name

Specialty

Official Photo

Signature



Hospital ID

Name

Specialty

Official Photo

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