ACCT _____ **EMURGENT CARE ENCOUNTER** DATE _____

NAME_____ DOB___/___/___ AGE_____GENDER: M F

ADDRESS_____ CITY_____ ST _____ZIP_____

PHONE _____ EMAIL _____

PHARMACY_____PRIMARY CARE PROVIDER_____

PRIMARY INSURANCE_____ ID #_____

REASON FOR VISIT_____

MEDICATIONS_____

MEDICATION ALLERGIES _____

DIAGNOSED MEDICAL CONDITIONS _____

Adult Social History:
Do you Smoke or Vape? Yes No
Any History of Second Hand Smoke? Yes No
Do you Consume Alcohol? Yes No
Use of Recreational Drugs? Yes No

Child Social History:
Live with parents? Yes No
Exposed to smoke? Yes No
Pets in home? Yes No

PATIENT/PARENT SIGNATURE _____DATE_____

BELOW FOR OFFICE USE ONLY	EST	NP	SP	F/U	MVA	WC	DS	DOT	EMT/FIRE	NV

CHIEF COMPLAINT: _____

_____

_____

_____

_____

WT_____ HT_____BP _____ OSAT _____ P_____ R_____ TEMP _____ LMP_____

PROVIDER ORDERS:

[__] Rapid Strep (**P** / **N**) [__] Throat Culture [__] UA Dipstick [__] UA Culture [__] Rapid Flu [**P** (A B) **N**]

[__] hCG (**P** / **N**) [__] Rapid Covid (**P** / **N**) [__] PCR Covid [__] Wound Culture [__] Nebulizer ALB / DUO

[__] IM Inj of _____mg _____ [__] X-ray of _____ [__] Splint

[__] Venipuncture [__] Glucose [__] Blood Draw (send out) _____

[__] RSV/FLU/Covid (send out) [__] PPD (L / R) [__] Other _____

MEDICATION _____

NEEDS REFERRAL TO _____

SPECIAL NOTES _____

PROVIDER SIGNATURE _____ **DATE** _____