

73015 Hwy 25 Covington, LA 70435

Phone: 985-400-5370



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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: _____