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FOLLOW-UP FORM

(*PLEASE COMPLETE ENTIRELY - PLEASE LIST ANY NEW CHANGES*)

DATE: _____ HT _____ WT_____BP_____TEMP_____

PATIENT NAME: _____DOB:_____AGE:_____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP:_____

PHONE: _____ SSN: _____

INSURANCE:_____ ID: _____

EMAIL: _____ (PLEASE SIGN UP FOR OUR PORTAL)

PCP NAME: _____ PHONE: _____

PHARMACY: _____STREET:_____ CITY: _____

REASON FOR TODAY'S VISIT: _____

_____

MEDICATION CHANGES: _____

ALLERGIES TO MEDICATIONS: _____

ANY CHANGES IN CLINICAL STATUS: _____

NEW LABORATORY OR RADIOLOGICAL STUDIES: _____

***PRESCRIPTIONS**: **NARCOTIC PRESCRIPTIONS WILL NOT BE REPLACED IF LOST OR STOLEN.** PLEASE HAVE YOUR PHARMACY SEND REFILL REQUESTS.

***APPOINTMENTS**: A **$40.00 NO SHOW FEE** WILL BE APPLIED TO YOUR ACCOUNT IF 24 HOUR NOTICE IS NOT GIVEN FOR APPOINTMENT CANCELLATIONS. INSURANCE COMPANIES **DO NOT** REIMBURSE FOR NO SHOW FEES. ***FILLING OUT FORMS**: THERE WILL BE A **$30.00 FEE** FOR FILLING OUT FORMS

PATIENT/GUARDIAN SIGNATURE: _____

OWED $ _____ PAID $ _____ CC CA CK # _____ POSTED ? Y N SCANNED _____