Date: ____________ Clinic Location: ______________________

PATIENT RETURN VISIT INFORMATION
Please Print

Date of last visit:_____________________ Medical Record Number:_______________

Reason for this visit:____

____________________	______________	______________	___________
Patient's Last Name	First Name	Middle Name	Maiden Name
Date of Birth	Age	☐ Male	☐ Female

Please update if changed from last visit:

____________________	______________	______________	___________
Patient's Address	City	State/Zip	Home Phone
Notify in Case of Emergency	Relationship	Phone Number	Other

____
Is Patient covered by Insurance, Medicare, or Medi-Cal?

I give consent for ____________________________ to be seen at the HOPE Medivan
Doy mi consentimiento para que Name of Patient *sea atendido en el HOPE Medivan*
(*Nombre de Paciente*)
for evaluation and treatment. (If you are the patient, please sign for yourself)
para evaluación y tratamiento. (*Si usted es el paciente, por favor firme por si mismo*)

_____________________ _____________________ __________
Signature (*Firma*) Relationship to Patient (*Relación con el Paciente*) Date (*Fecha*)

Registration Clerk: __________________________ Time:_____________

Triage Documentation					
ALLERGIES: ☐ NKDA					LMP:_______
MEDICATIONS:					
CHIEF COMPLAINT:					
ADDITIONAL NOTES:					
Weight: _____ lbs / kg ☐ Verbal ☐ Scale		Height: ____ Inches / Centimeters / Estimate ☐ Verbal ☐ Measured			
TIME	TEMPERATURE	ROUTE	PULSE	BP	RESPIRATIONS
__:__				/	

Triage Staff: ______________________ Interpreter: _________________