

# Walk-In

**Attention:** PATIENTS WILL BE SEEN BY PRIORITY BASED UPON THE SEVERITY OF THEIR ILLNESS OF INJURY. THERE ARE SOME MEDICATIONS THAT MAY NOT BE REFILLED ON A WALK-IN BASIS (SUCH AS MEDICATIONS FOR PAIN AND ANXIETY.)

PLEASE INFORM THE NURSE AT ONCE IF YOU ARE EXPERIENCING HEART PROBLEMS OR HAVING DIFFICULTY BREATHING.

**DATE (Fecha):** \_\_\_\_\_

**NAME (Nombre):** \_\_\_\_\_

**AGE (Edad):** \_\_\_\_\_

**D.O.B (La fecha de Nacimiento):** \_\_\_\_\_

**PHONE NUMBER (Numero de telefono):** \_\_\_\_\_

**REASON FOR VISIT (Razon para la Visita):**

(Please list symptoms or please specify if this is related to an injury. A nurse will evaluate your medical problem to assure that you are seen by an appropriate provider.)

*(Por favor mencione sus sintomas o si este problema esta relacionado con un accidente en su trabajo. Una enfermera evaluara su problema medico para asegurar que usted es visto por un proveedor apropiado.)*

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**PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:**

*(Por favor liste todas sus medicinas que esta tomando actualmente.)*

**MEDICATION (Medicina):**

**DOSAGE (Dosis):**

**TIME (Frecuencia):**

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You are very important to us and we are making every effort to assist you as quickly and efficiently as possible. Thank you for your patience.