NP Walk-In Clinic
www.npclinictn.com
615.306.9996
Lavonne Clifford, MSN, ARNP, FNP-C, CEN

Patient Information/Injection Form

First_____ M.I._____ Last_____

Sex: Male / Female Date of Birth_____/_____/_____

Address_____City_____

State_____ Zip Code_____ Cell Phone (_____)_____-_____

Email_____How did you hear about us?_____

MEDICATIONS: (Please list all medications you are currently taking)

_____ _____

_____ _____

_____ _____

_____ _____

ALLERGIES (Please list any allergies you are aware of): _____

HEALTH HISTORY (Please circle any that apply to you) : Heart Disease, Heart Murmur, ADHD, Thyroid, Stroke, Heart Attack, Sleep Apnea, Seizures, Psychosis, Liver Disease, Cardiac Surgery, Glaucoma, Eating Disorder, Renal Disease, Diabetes

Release of Liability

By providing my signature below, I certify that I have discussed with the provider all possible side effects related to the injection that I am receiving. By providing my signature, this represents that all of the information on this form is true to the best of my knowledge. I am not pregnant or breastfeeding at this time. I am aware that the provider here is not my personal medical provider and will not be conducting a full examination. I give my full consent for this clinic from any liability and its providers/employees from any and all injuries and losses that I may sustain as a result of any misrepresentation that I made in my medical history. I understand that this release of liability is ongoing until such time that I make necessary corrections.

*Patient Signature*_____

*Date*_____