Flagler County Free Clinic

PATIENT REQUEST FORM

THIS DOCUMENT MUST BE COMPLETED IN ITS ENTIRETY!!

DATE:_____

NAME:_____DOB:_____

MEDICAL RECORDS #:_____FINANCIALS EXPIRE:_____

CONTACT TELEPHONE NUMBER:_____

DATE OF LAST MEDICAL VISIT HERE:_____

 # OF NO SHOWS:_____# OF CANCELLATIONS:_____

I NEED THE FOLLOWING:

AN APPOINTMENT:_____ MY MEDICAL RECORDS:_____

PRESCRIPTION REFILL:_____ NAME OF MEDICATION(S) AND DOSEAGE:

_____

_____

_____

MISCELLANEOUS_____

_____

_____

_____

REMAINDER FOR CLINIC USE ONLY!

RESOLUTION:_____

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CLOSED BY:_____DATE:_____

(Revised 7/26/2021)