## PAIN INSTACARE - FRONT SHEET

Patient Name		DOB Pharm								
Address										
Phone										
Allergies:	NKDA			Medicatio	ns					
	Iodine / X-ray Dye Lidocaine / Depomedrol / PCN / Sulfa / Band-Aid			IBUPROFEN / NAPROXEN / GABAPENTIN / TOPAMAX						
Blood Thinners	Heparin/Aspiri	in/Coumadin/P	lavix/Pradaxa / Eliquis Other	TRAMADOL / FLEXERIL / TIZANADINE / LIDODERM / VOLTAREN						
Date Of Visit	Visit Type (NP / FU /PRO)	PRE	Procedure Performed	Consent Signature	BILLED	PAYMENT PRIM SEC		STATEMENT		
Referral:	,,									
	NP									
	FU /PRO/TH									
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