McLAREN FLINT
Flint, Michigan

IV THERAPY CLINIC WORKSHEET

Date: _____ / _____ / _____

Patient Name: ____________________

SS #: ____________________

DOB: _____ / _____ / _____

Dr.: ____________________

Nurse: ____________________

Diagnosis: ____________________

Procedure: ____________________

Appointment Date/Time: _____ / _____ / _____ __________ am / pm

Insurance Information Requested: ☐ yes ☐ no

Signature: ____________________

Comments: ____________________

Ht: Wt: Allergies:

M-1911 (10/12)

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