



Provider Information	Patient Information
Provider/Physician Name	Patient's Name
Referring Clinic	Patient's DOB
Phone # : Email:	Date of Service
Address:	
I would like to receive follow up: □Phone □Email □Not Needed □Send Full Medical Record	

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IMMEDIATE TREATMENT FOR:

Abdominal Pain

Patient's Signature _____

Allergic Reaction

Chest Pain

Difficulty Breathing

Fever/Flu

Head or Neck Trauma

Heart Attack

Infections

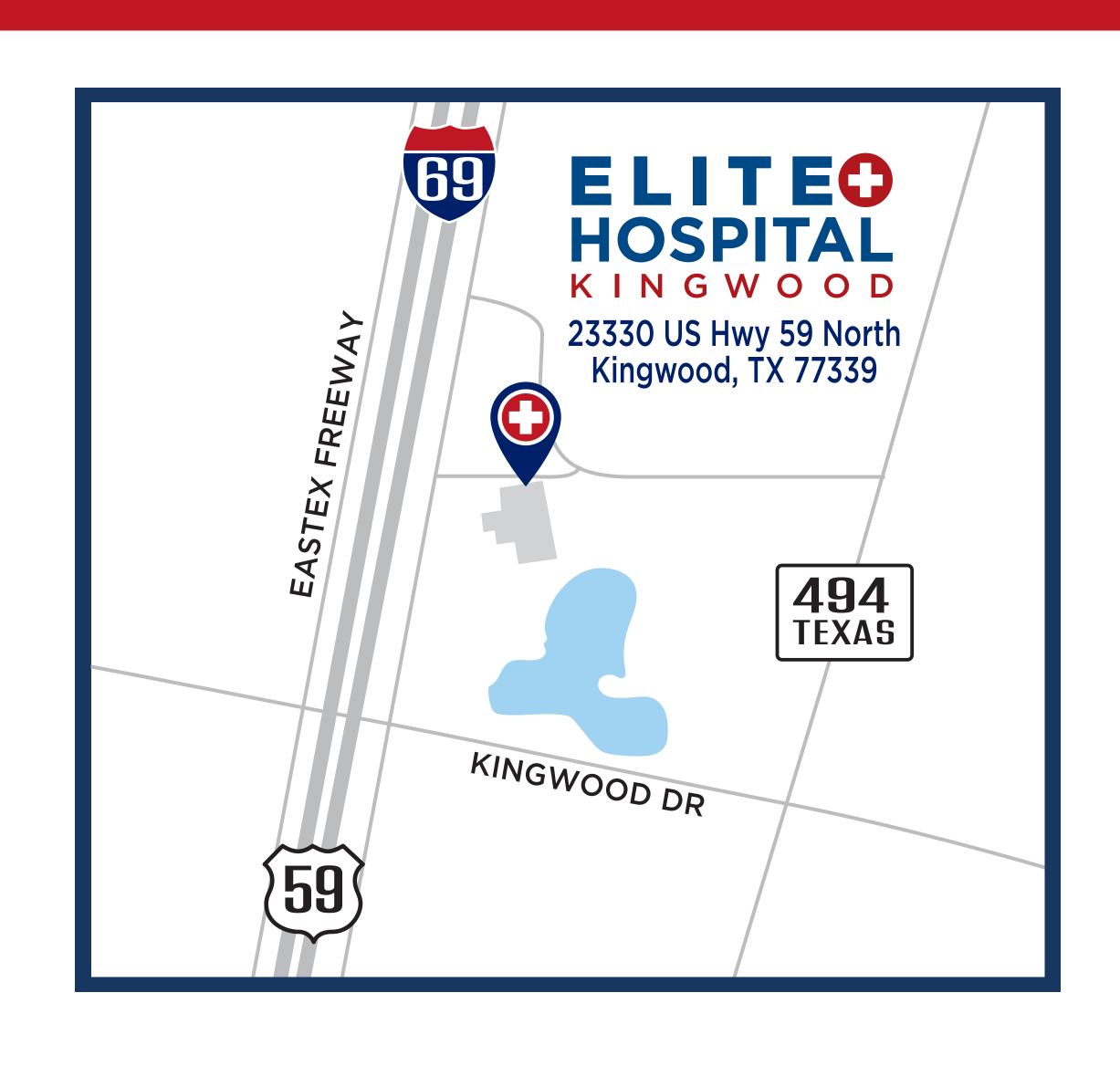
Lacerations

Respiratory Distress

Sports Injuries

Stroke

and more ...



Date _____