URGENT CARE+
Care at Your Convenience

www.mylocalurgentcare.net

Patient:_____ Gender: O Female O Male

Last name First name Middle initial

Race: O American Indian or Alaska Native O Asian O Black or African American O Hispanic or Latino

O Native Hawaiian or Other Pacific Islander O White

Patient Date of Birth: _____ Social Security number:_____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone (_____)_____Work Phone (_____)_____Cell Phone (_____)_____

Primary Care Physician: _____Phone #: _____

PLEASE COMPLETE THE FOLLOWING INSURANCE INFORMATION ON THE *POLICY HOLDER*:

Primary Insurance Name:_____ Secondary Insurance name: _____

Subscriber's name: _____ _____ Subscriber's name: _____

Subscriber's DOB: _____ Subscriber's DOB: _____

Subscriber's SSN: _____ Subscriber's SSN: _____

Which pharmacy would you like to use?

_____

Emergency Contact: _____ Phone #:_____ Relationship: _____

I authorize the office of Urgent Care to release any medical information required during the course of examination and treatment. Furthermore I permit payment directly to them any benefits due for their services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes but is not limited to co-insurance, co-payment, deductible and non-covered services.

Today's Date: _____ Signature of patient: _____

(If minor, signature of responsible party)

PATIENT'S NAME: _____Date of Birth_____
TODAY'S DATE: _____

Reason for today's visit:

_____
_____
_____

Medication List: WE MUST HAVE CURRENT DOSAGES AND FREQUENCY OF USE LISTED.

If you do not know please contact your pharmacy.

If you do not take any prescribed Medication please check here. ☐

Are immunizations up to date? ○ **Yes** ○ **No**

Please circle any of the following conditions are you currently being treated for, or have been treated for in the past.

Heart disease / Murmur / Angina	**Shortness of Breath**	**Eye disorder / Glaucoma**	**High / Low Blood Pressure**	**Diabetes**
High Cholesterol	**Heartburn / Reflux**	**Sinus problems**	**Seizures**	**Asthma**
Lung problems / cough	**Anemia or blood problems**	**Swollen Ankles**	**Headaches / Migraines**	**Stroke**
Liver problems / Hepatitis	**Psychiatric care**	**Seasonal allergies**	**Tonsillitis**	**Arthritis**
Kidney / Bladder problems	**Depression / Anxiety**	**Neurological problems**	**Ear problems**	
Cancer	**Ulcers / colitis**	**Thyroid problems**		

Please describe any current or past medical treatment not listed above :

Please list your past surgeries:

Allergies :
Are you allergic to penicillin or any other drugs?

List All Allergies:

Female: When was the first day of your last menstrual period? __/__/____

Do you currently smoke or chew tobacco? ○ **Yes** ○ **No** **If yes, how many packs a day?_____** **If no, have you in the past?** ○**Yes** ○ **No**

Do you drink alcohol, beer, or wine? ○ **Yes** ○ **No** **If yes, how many drinks per week? _____** **If no, have you in the past?** ○ **Yes** ○ **No**