ADVANCED URGENT CARE
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**NOTIFY THE RECEPTIONIST IMMEDIATELY IF YOU FEEL YOU HAVE A POTENTIALLY LIFE THREATENING SYMPTOM OR INJURY**

## **Section 1:** General Information

**Patient Name:**_____ **Date of Birth**_____
Last Name First Name M.I.

**Marital Status:**_____ **Gender:** ❑ Male ❑ Female **Social Security #**_____

**Address**_____
Street Address City State Zip

**Home Phone**_____ **Cell/Work Phone**_____

**Email**_____

**Which Category best describes your race? (Check One)**

- ❑ American Indian
- ❑ Asian
- ❑ Black or African American
- ❑ European
- ❑ Other Race
- ❑ White
- ❑ Decline to Answer

**What category best describes your ethnicity? (Check One)**

- ❑ Central American
- ❑ Cuban
- ❑ Dominican
- ❑ Hispanic or Latino/Spanish
- ❑ Latin American/Latin, Latino
- ❑ Mexican
- ❑ Not Hispanic or Latino
- ❑ Puerto Rican
- ❑ South American
- ❑ Spaniard
- ❑ Decline to Answer

**Emergency Contact**_____ **Phone**_____

**Primary Care Physician**_____ **Phone**_____

## **Section 2:** Insurance Information (Primary Card Holder information)

**Insurance Card Holder**_____
Last Name First Name M.I.

**Insured's Address**_____
Street Address City State Zip

**Insured's Social Security#**_____ **Date of Birth**_____

**Insured Phone Number**_____ **Relationship to Patient**_____

- I agree to pay any and all court or attorney fees accrued if this account is assigned to a collection agency for non-payment.
- Returned checks may be subject to a $25.00 charge plus allowable fees.

### Authorization to Release Information and Assignment of Benefits

Authorization is hereby granted to release to my insurance company(ies) of record such information as may be necessary for the completion of my claims. I understand that I am financially responsible for charges not covered by insurance and assign any insurance benefits to the above said clinic.

_____/_____
Signature Date

If patient is a **minor**, at least one Parent/Guardian **must sign**, although both parents are financially responsible.

_____/_____
Print Name of Parent or Guardian Signature of Parent or Guardian

I have **read** and **understand** the HIPPA Policy for Advanced Urgent Care

_____/_____
Signature Date

## **Section 3:** Reason for Visit

**Reason for visit:**_____

Is this visit Work Related? ❑ No ❑ Yes  Is this visit Auto Accident Related**?** ❑ No ❑ Yes

## **Section 4:** Health History

### Surgical History

Procedure_____ ❑ Left ❑ Right  Date of Surgery:_____
Procedure_____ ❑ Left ❑ Right  Date of Surgery:_____
Procedure_____ ❑ Left ❑ Right  Date of Surgery:_____

### Medications

List all your medications (include birth control pill/injection, inhalers, vitamins, etc.):_____

**Last Tetanus Shot?**_____
mo/year

### Allergies

List all Drug/Food Allergies:_____

### Past Medical History

Check all that apply:

| | | |
|---|---|---|
| ❑ Abdominal Pain (Chronic) | ❑ Diabetes | ❑ Liver Disease |
| ❑ Anemia | ❑ Diverticulitis | ❑ Muscle, Joint or Bone Problems |
| ❑ Asthma/ COPD/other Lung Disease | ❑ Rheumatologic Disease/ | ❑ Pulmonary Embolism/Blood Clots |
| ❑ Birth Defect | Arthritis/Fibromyalgia | ❑ Seizures/Epilepsy |
| ❑ Bladder or Kidney Problems | ❑ GERD/reflux | ❑ Serious Illness or Injuries |
| ❑ Blood Diseases | ❑ Heart Problems/Disease | ❑ Stroke |
| ❑ Cancer | ❑ Hospital Admission other than birth | ❑ Thyroid Problems |
| ❑ Depression/Anxiety | ❑ Hypertension | ❑ Other:_____ |

If you checked any of the above, please explain:_____

### Family History:

List any significant family history of problems:_____

### Social History

Smoking Status? ❑ No ❑ Yes ❑ Tobacco ❑ Marijuana  If Yes, How Much?_____
Alcohol Intake? ❑ No ❑ Yes  If Yes, How Much?_____
Illicit Drug Use? ❑ No ❑ Yes  If Yes, How Much?_____