Walk In Urgent Care

Registration/Health Hitory Form

Name: (Last, First, Middle).....Birth Date:.....

Address:.....City.....Zip Code:.....Ph:.....

SSN:.....Gender: M F Marital Status: M S D W Email:.....

Employer Name:.....Work Phone:.....

Primary Care Physician:.....Ph:.....

Emergency Contact:.....Phone:.....Relationship:.....

Insurance Policy Holder: (if other than patient)

Name:.....Address:.....

Relationship to patient:.....SSN:.....DOB:.....

Pharmacy Name:.....Location:.....Phone Number:.....

How did you hear about us? ☐ *Family/Friend* ☐ *Website* ☐ *Internet* ☐ *Post Card* ☐ *Facebook* ☐ *Other*

Previous/Chronic Illnesses: *(Check each item Yes or No; If yes, write "C" if the problem still exists)*

Have you had?	*Yes*	*No*	*Have you had?*	*Yes*	*No*	*Have you had?*	*Yes*	*No*	*Have you had?*	*Yes*	*No*
Arthritis			*High B.P.*			*Liver Disease*			*Measles*		
Anemia			*Heart Attack*			*Kidney Disease*			*Meningitis*		
Bleeding Disorder			*Heart Disease*			*Kidney Stone*			*Mononucleosis*		
Allergies/Hay Fever			*Stroke*			*Diabetes*			*Pneumonia*		
Asthma			*Seizures*			*Thyroid Disease*			*Tuberculosis*		
Emphysema/COPD			*Hepatitis*			*Chicken Pox*			*Cancer*		

DISABILITIES *(including learning)* & ***OTHER ILLNESSESS*** *not listed above:.....*

.....

Family History: *Among your blood relatives, has anyone had the following? (Check appropriate boxes)*

Family History of:	*If yes, who has/had it?*	*Family History of:*	*If yes, who has/had it?*
Asthma		*Tuberculosis*	
Diabetes		*Mental Disease*	
High Blood Pressure		*Breast Cancer*	
Heart Attack		*Cervical Cancer*	
Heart Disease (other)		*Colon Cancer*	
Stroke		*Prostate Cancer*	
Seizure/Epilepsy		*Other*	

HIPPA COMPLIANCE: *By my signature below, I acknowledge the receipt of &/or have read the Notice of Privacy Practices (NPP) which describes in detail how your health information may be used and disclosed, and how you can access this information. (Ask for a copy of Privacy Notice if you did not see or receive one).*

CONSENT: *I hereby authorize Excel Urgent Care/Walk-In Urgent Care & its provider(s) to perform the necessary exams/procedures for the health assessment and treatment of myself and/or my children, and to furnish the resulting health information to appropriate parties.*

Payment/Billing Procedure: *By signing below I have read and understand the payment and billing procedure, and that I was given the opportunity to ask questions for further clarification regarding the company's payment and billing process. (Ask for a copy if you did not see or receive one) Copies available upon request.*

SIGNATURE: .....Relationship with patient:.....DATE:.....