# Walk In Urgent Care

## Registration/Health History 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:..................................................*

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

| Family History of: | Yes | No | If yes, who has/had it? | Yes | No | Family History of: | Yes | No | 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:.......................*