# *Peachtree City Urgent Care*

## REGISTRATION FORM

### PATIENT INFORMATION

| | | | |
|---|---|---|---|
| **Patient's Last Name:** | **First:** | | **Middle:** |
| **Race:** | **Language:** | | |
| **Birth date:** | **Age:** | **Sex:** ❑ M ❑ F | **Marital Status :** ❑ Single ❑ Divorced ❑ Married ❑Widowed |
| **Address:** | **City:** | **State:** | **ZIP Code:** |
| **Social Security #** | | **Home Phone #** | |
| **Reason for visit:** | | **Cell Phone #** | |
| | | **E-Mail:** | |
| **If the reason for visit is an injury/laceration did it happen at work?** ❑ Yes ❑ No ❑ N/A | | **Has the patient been seen here previously?** ❑ Yes ❑ No **If no, how did you hear about us?** | |

### Medicare/Medicaid

| | | | | |
|---|---|---|---|---|
| **Medicare** ❑ Yes ❑ No | **Medicare #** | **Medicaid** ❑ Yes ❑ No | **Medicaid #** | **Effective Date:** |
| **Medicare Secondary Insurance Name** | | **Address** | | |

### INSURANCE INFORMATION

| | | |
|---|---|---|
| **Person responsible for bill:** | | **Address (if different):** |
| **Home phone #** | | **Cell Phone #** |
| **Primary Insurance** | **Member ID #** | **Group #** |
| **Subscriber's Name:** | | **Subscriber's Birth Date:** |
| **Patient's relationship to subscriber:** ❑ Self ❑ Spouse ❑ Child ❑ Other | | |
| **Secondary Insurance:** | **Member ID #** | **Group #** |
| **Subscriber's Name:** | | **Subscriber's Birth Date:** |
| **Patient's relationship to subscriber:** ❑ Self ❑ Spouse ❑ Child ❑ Other | | |

# Peachtree City Urgent Care

Medical History/Medication Sheet

List all your current medications including non-prescription drugs: ❑ **None**

| Medications/Vitamins | Strength (Ex. 50mg) | Directions (Times a day) | | Medications/Vitamins | Strength (Ex. 50mg) | Directions (Times a day) |
|---|---|---|---|---|---|---|
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Medication Allergies: _____ ❑None Known

## Past Medical History (Check all that apply)

❑ Alcoholism ❑ Allergies ❑ Anxiety ❑ Asthma ❑ Arthritis

❑ Cancer (Specify) _____ ❑ Depression ❑ Diabetes: Type I or Type II (circle)
❑ Emphysema/COPD (circle)

❑ Epilepsy/Seizure Disorder ❑ Headaches ❑ Heart Disease ❑ High Blood Pressure ❑ High Cholesterol

❑ Kidney Disease ❑ Liver Disease ❑ Stroke ❑ Thyroid Disease

❑ Other (Specify) _____ ❑ None Apply

**Children Only:** Immunizations up to date? ❑ Yes ❑ No **Females only:** Last menstrual cycle? _____

## Hospitalization & Surgery (Check all that apply and write date next to surgery)

❑ Appendix _____ ❑ Adenoids _____ ❑ Back _____ ❑ Breast _____

❑ Gall Bladder _____ ❑ Heart Surgery _____ ❑ Hernia _____ ❑ Hysterectomy _____

❑ Tonsillectomy _____ ❑ Tubal Ligation _____ ❑ Vasectomy _____

❑ Other (Specify) _____ ❑ None Apply

## Family History (Check all that apply)

❑ Asthma ❑ Cancer (Specify)_____ ❑ Dementia/Alzheimer's ❑ Depression ❑ Diabetes

❑ Heart Disease ❑ High Blood Pressure ❑ High Cholesterol ❑ Stroke ❑ Thyroid disease

❑ Other (Specify) _____ ❑ None Apply

## Social History

Do you smoke? ❑ Yes ❑ No How many cigarettes per day? _____

Have you ever smoked? ❑ Yes ❑ No If yes, how many cigarettes did you smoke per day? _____

Do you drink alcohol? ❑ Yes ❑ No How many drinks per week? _____

Do you use recreational drugs? ❑ Yes ❑ No

Do you live alone? ❑ Yes ❑ No