Urgent Care Clinic of Anna
Patient Registration

Date: ______________ SSN: ______________
Patient: ____________________________ Gender: M ( ) F ( ) DOB: ___/___/___
Address: ______________________ Apt. #_____ City: ________State: ___ Zip: ______
Home Phone: ___________________ Cell Phone: ____________________
E-mail: ____
Employer: __________________________________ Work Phone: ________________
Spouse: ____________________________DOB:___/___/___ SSN: ________________
Spouse's Employer: ___________________________Spouse's Cell: _______________

PLEASE FILL OUT ONLY IF CHILD IS A MINOR

Mother (*if a minor*): ____________________ DOB:___/___/___SSN: ___________
Employer:____________________ Work Phone:____________________
Father (*If a minor*): _____________________ DOB: ___/___/___ SSN: ___________
Address of Policy Holder/Guarantor's: ___________________________
City: ________________ State: ______ Zip: ____________ Home/Cell Phone:
____

Emergency Contact Person: ________________ Relation: __________ Ph.: __________

Insurance Information:
Policy Holder/ Guarantor's Name: ______________ Relation to policy holder: _________
Policy Holder SSN: ________________ Policy Holder's DOB: ___/___/___
Policy Holder's Employer: ___________________________ Ph.: ________________

We file your insurance as a courtesy. It is to your advantage to become familiar with your health information benefits.

All persons covered under this policy:

________________________________ ______________________________
________________________________ ______________________________
________________________________ ______________________________

How did you hear about us? ____

Urgent Care Clinic of Anna New Patient Record

NAME:________________________________ Date of Birth:__________

CURRENT MEDICATIONS
(prescription, herbs, over the counter)

1)____________________
2)____________________
3)____________________
4)____________________
5)____________________

SURGERIES
(please list year)

1)______________
2)______________
3)______________
4)______________
5)______________

FAMILY MEDICAL HISTORY

	Health is:			
Relative	Age	Good	Poor	Deceased
Mother	____	____	____	____
Father	____	____	____	____
Sister	____	____	____	____
Brother	____	____	____	____
Child	____	____	____	____

Causes of death:______________________________
____
____

MEDICAL ILLNESSES______________________________
____
____

CURRENT ALLERGIES OR SENSITIVIES: LIST ANYTHING YOU ARE ALLERGIC TO AND HOW IT AFFECTS YOU.

____
____
____
____

ARE YOU:
SINGLE/MARRIED/SEPERATED/DIVORCED/WIDOWED
CHILDREN: Girls: _________ Boys: __________
CURRENTLY EMPLOYED: Yes_______ No_______
Homemaker/Retired/Disabled
PRESENT TYPE OF WORK/EMPLOYER

____

PERSONAL HABITS

	NEVER	SOMETIMES	OFTEN
REGULAR EXERCISE	_____	_____	_____
WEAR SEAT BELT	_____	_____	_____
BRUSH TEETH	_____	_____	_____
SLEEP WELL	_____	_____	_____
EAT BALANCED MEALS	_____	_____	_____
HAPPY WITH LIFE	_____	_____	_____
FEEL LONELY	_____	_____	_____
FEEL ANXIOUS/NERVOUS	_____	_____	_____
USE DRUGS	_____	_____	_____
SMOKE/CHEW TOBACCO	_____	_____	_____
DRINK ALCOHOL	_____	_____	_____

If you (P) or a member of your Family: Father (F), Mother (M) Sibling (S) or children (C) have had the following illnesses or problems, list the appropriate initials:

Allergies ______________
Asthma______________
Arthritis______________
Alcohol/Drug Problem_______
Anemia or blood disease______
Cancer______________
Cholesterol Problem________
Depression______________
Diabetes______________
Eczema/Rashes___________
Epilepsy______________
High blood pressure_________
Heart disease______________
Kidney disease_____________
Liver disease______________
Lung problems_____________
Mental illness_____________
Osteoporosis______________
Stomach problems__________
Suicide attempt____________
Thyroid problems___________
Other______________