TRACY URGENT CARE MEDICAL CLINIC, INC

DATE:_____

PATIENT REGISTRATION

PATIENT INFORMATION

PATIENT NAME: LAST:_____ FIRST:_____ MI:_____
If a minor, list parent or guardian's name and relation:_____
DATE OF BIRTH: _____/_____/_____ SS#:_____/_____/_____ SEX: M_____ F_____
ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____
HOME#:_____ CELL#:_____ EMAIL:_____
PRIMARY LANGUAGE SPOKEN:_____ PRIMARY CARE PHYSICIAN :_____
PHARMACY:_____PHONE #: _____ LOCATION: _____
ALLERGIES TO MEDICATIONS:_____
LIST OF CURRENT MEDICATIONS:_____
REASON FOR VISIT:_____

EMERGENCY CONTACT:

LAST NAME:_____FIRST:_____RELATIONSHIP:_____
PHONE #: _____ ADDRESS:_____CITY:_____
STATE:_____ ZIP:_____

INSURANCE INFORMATION:

NAME OF PRIMARY INSURANCE COMPANY:_____ HMO_____ PPO _____ POS _____
SUBSCRIBER ID#_____ GROUP#_____
POLICY HOLDER:_____ RELATIONSHIP:_____
ADDRESS:_____CITY:_____ STATE:_____ ZIP:_____
POLICY HOLDER'S DATE OF BIRTH:_____/_____/_____ SS #:_____
HOME PHONE #: _____ WORK PHONE#:_____

SECONDARY INSURANCE:

SECONDARY INSURANCE COMPANY:_____ HMO_____ PPO _____ POS _____
SUBSCRIBER ID#_____ GROUP#_____
POLICY HOLDER:_____ RELATIONSHIP:_____
ADDRESS:_____CITY:_____ STATE:_____ ZIP:_____
POLICY HOLDER'S DATE OF BIRTH:_____/_____/_____ SS #:_____
HOME PHONE #: _____ WORK PHONE#:_____

MEDICAL HISTORY QUESTIONNAIRE

(Please circle any that apply)

PAST MEDICAL HISTORY (circle)	PAST SURGICAL HISTORY (circle)
None ☐	None ☐
High Blood Pressure ☐	Open Heart ☐
Diabetes ☐	Angioplasty ☐
Chronic Bronchitis ☐	Gallbladder ☐
Emphysema ☐	Back or knee ☐
Seizures ☐	Appendectomy ☐
Strokes ☐	Other:
Asthma ☐	
Cardiac Disease ☐	
Other:	

SOCIAL HISTORY (Please circle)

Do you smoke? YES / NO **If yes, how much and for how many years?**

Do you drink alcohol? YES / NO **If yes,**

Do you take any drugs that are not prescribed to you? YES / NO

FAMILY HISTORY (Please circle)

Diabetes ☐	Stroke ☐	Coronary Artery Disease ☐
Cancer (type) ☐	High Blood Pressure ☐	Other: