1st Choice URGENT CARE

Date: _____

Name: _____ **Date of Birth:** _____
Last First MI

Street Address: _____**City:** _____ **State:** _____ **Zip:** _____

Social Security Number: _____**Home Phone:** (____) _____-_____ **Cell:** (____) _____-_____

Gender: M / F Email Address: _____

Emergency Contact: _____ **Relationship:** _____ **Phone #: (____)** _____-_____

Insurance Information

Insurance Carrier: _____ **ID #:** _____ **Group #:** _____

Subscriber: _____ **Relationship:** _____ **DOB:** _____

Secondary Carrier: _____ **ID #:** _____ **Group #:** _____

Subscriber: _____ **Relationship:** _____ **DOB:** _____

Is Your Visit Work or Auto Related? ____ Yes or ____ No

Date of Injury: _____ **Time:** _____ **am/pm** **Employer:** _____

Address: _____ **City:** _____ **Zip:** _____ **Phone:** _____

Contact Person: _____ **Claim #:** _____

Reason for visit: _____

Allergies: _____

Medical History:
__ Hypertension
__ Diabetes
__ High Cholesterol
__ Asthma
__ COPD
__ Stroke
__ Cancer: _____
__ Other: _____

Family History:
__ Hypertension
__ Diabetes
__ High Cholesterol
__ Asthma
__ COPD
__ Stroke
__ Cancer: _____
__ Other: _____

Medications: _____

Primary Care Physician: _____ Phone: (____) _____-_____

Pharmacy: _____ **City:** _____ **Phone:** _____

How did you hear about us? Internet (please list): _____

PLEASE RETURN TO FRONT DESK ONCE COMPLETED WITH YOUR DRIVER'S LICENSE & INSURANCE CARD