ASHWIN R PATEL, MD, PLLC *URGENT CARE OF ARIZONA, LLC*

PATIENT REGISTRATION FORM

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____

Email Address: _____

Gender: ◯ Male ◯ Female ◯ Married ◯ Single ◯ Widowed ◯ Divorced

Employment: ◯ Retired ◯ Employed ◯ Unemployed ◯ Student

Employer: _____

Work Phone: _____

EMERGENCY CONTACT

Name: _____ **Relationship** _____ **Phone #** _____

I give permission to discuss my medical information with the following person(s) _____

_____

How Did You Hear About Us? _____

PRIMARY INSURANCE _____

ID# _____

Group# _____

Policy Holder Name _____

Policy Holder Date of Birth _____

SS# of Policy Holder _____

SECONDARY INSURANCE _____

ID# _____

Group# _____

Policy Holder Name _____

Policy Holder Date of Birth _____

SS# of Policy Holder _____

Patient Signature: _____ Date: _____

Patient Guardian: _____ Signature: _____ Date _____

GENERAL MEDICAL HISTORY

ALLERGIES:

_____

_____

MEDICATIONS:

_____

_____

_____

HOSPITALIZATIONS:

_____

_____

_____

TOBACCO ASSESSMENT:

◯ Never Smoked ◯ Tobacco User

packs _____ years _____ Date quit smoking _____

SOCIAL HISTORY:

Alcohol use: _____ Drinks per day _____ Non-Drinker _____

Caffeine use: _____ Cups per day _____ No Caffeine _____

SURGERIES/PROCEDURES:

◯ No Prior Surgical History

◯ Appendectomy
◯ Breast Lumpectomy
◯ Endometrial Ablation
◯ Cataract Surgery
◯ Gall Bladder
◯ Heart Surgery
◯ Hernia
◯ Hemorrhoids
◯ Hysterectomy
◯ Laparoscopy
◯ Mastectomy

Other Surgical /Procedure History:

_____

_____

YOUR GENERAL MEDICAL HISTORY

◯ Yes	◯ No	Alcoholism	◯ Yes	◯ No	Depression	◯ Yes	◯ No	Kidney Functions
◯ Yes	◯ No	Allergies/ Hay Fever	◯ Yes	◯ No	Diabetes Type I	◯ Yes	◯ No	Kidney Stone
◯ Yes	◯ No	Anemia	◯ Yes	◯ No	Diabetes Type II	◯ Yes	◯ No	Migraine
◯ Yes	◯ No	Anxiety	◯ Yes	◯ No	Epilepsy	◯ Yes	◯ No	Multiple Sclerosis
◯ Yes	◯ No	Asthma	◯ Yes	◯ No	Fracture	◯ Yes	◯ No	Obesity
◯ Yes	◯ No	Atrial Fibrillation	◯ Yes	◯ No	Gastric Ulcer	◯ Yes	◯ No	Old MI
◯ Yes	◯ No	Blood Transfusions	◯ Yes	◯ No	Gastro Disease	◯ Yes	◯ No	Osteoarthritis
◯ Yes	◯ No	CAD	◯ Yes	◯ No	GERD	◯ Yes	◯ No	Osteoporosis
◯ Yes	◯ No	Cancer	◯ Yes	◯ No	Gestational Diabetes	◯ Yes	◯ No	Pneumonia
◯ Yes	◯ No	Cardiac Pacemaker	◯ Yes	◯ No	Glaucoma	◯ Yes	◯ No	Prog Neuro Disease
◯ Yes	◯ No	Cardiovascular Disease	◯ Yes	◯ No	Heart Murmur	◯ Yes	◯ No	Pulmonary Disease
◯ Yes	◯ No	CHF	◯ Yes	◯ No	Hepatitis	◯ Yes	◯ No	Rheumatic Fever
◯ Yes	◯ No	Cirrhosis	◯ Yes	◯ No	High Cholesterol	◯ Yes	◯ No	Rheumatoid Arthritis
◯ Yes	◯ No	Colitis	◯ Yes	◯ No	Hyperlipidemia	◯ Yes	◯ No	STD
◯ Yes	◯ No	COPD	◯ Yes	◯ No	Hypertension	◯ Yes	◯ No	Terminal Illness
◯ Yes	◯ No	CRF	◯ Yes	◯ No	Hyperthyroidism	◯ Yes	◯ No	Thyroid Disease
◯ Yes	◯ No	Crohn's Disease	◯ Yes	◯ No	Insulin Pump	◯ Yes	◯ No	TIA
◯ Yes	◯ No	CVA	◯ Yes	◯ No	Joint Pain	◯ Yes	◯ No	Tuberculosis
◯ Yes	◯ No	DVT				◯ Yes	◯ No	Valvar Problems

MOTHER-GENERAL HISTORY (circle one) Living Deceased In Good Health

◯ Yes	◯ No	Alcoholism	◯ Yes	◯ No	Congenital Anomaly	◯ Yes	◯ No	Hypertension
◯ Yes	◯ No	Anemia	◯ Yes	◯ No	COPD	◯ Yes	◯ No	Hypothyroidism
◯ Yes	◯ No	Anxiety	◯ Yes	◯ No	Crohn's Disease	◯ Yes	◯ No	Kidney Disease
◯ Yes	◯ No	Asthma	◯ Yes	◯ No	Depression	◯ Yes	◯ No	Liver Disease
◯ Yes	◯ No	Birth Defects	◯ Yes	◯ No	Diabetes	◯ Yes	◯ No	Multiple Births
◯ Yes	◯ No	CAD	◯ Yes	◯ No	Epilepsy	◯ Yes	◯ No	Osteoarthritis
◯ Yes	◯ No	Cardiovascular Disease	◯ Yes	◯ No	GERD	◯ Yes	◯ No	Osteoporosis
◯ Yes	◯ No	CHF	◯ Yes	◯ No	High Cholesterol	◯ Yes	◯ No	Pulmonary Disease
◯ Yes	◯ No	Cancer	◯ Yes	◯ No	Hyperlipidemia	◯ Yes	◯ No	Stroke

Other Conditions _____

FATHER-GENERAL HISTORY (circle one) Living Deceased In Good Health

◯ Yes	◯ No	Alcoholism	◯ Yes	◯ No	Congenital Anomaly	◯ Yes	◯ No	Hypertension
◯ Yes	◯ No	Anemia	◯ Yes	◯ No	COPD	◯ Yes	◯ No	Hypothyroidism
◯ Yes	◯ No	Anxiety	◯ Yes	◯ No	Crohn's Disease	◯ Yes	◯ No	Kidney Disease
◯ Yes	◯ No	Asthma	◯ Yes	◯ No	Depression	◯ Yes	◯ No	Liver Disease
◯ Yes	◯ No	Birth Defects	◯ Yes	◯ No	Diabetes	◯ Yes	◯ No	Multiple Births
◯ Yes	◯ No	CAD	◯ Yes	◯ No	Epilepsy	◯ Yes	◯ No	Osteoarthritis
◯ Yes	◯ No	Cardiovascular Disease	◯ Yes	◯ No	GERD	◯ Yes	◯ No	Osteoporosis
◯ Yes	◯ No	CHF	◯ Yes	◯ No	High Cholesterol	◯ Yes	◯ No	Pulmonary Disease
◯ Yes	◯ No	Cancer	◯ Yes	◯ No	Hyperlipidemia	◯ Yes	◯ No	Stroke

Other Conditions _____