STATMED QUICK QUALITY URGENT CARE
REGISTRATION FORM

(Please Print)

Today's date:			PCP:			
PATIENT INFORMATION						
Patient's last name: First:		Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	(Former Name)	Social Security no.:	Birth date: / /	Age:	Sex: ❑ M ❑ F	Race:
Street address:					Home phone #: ( )	
P.O. box:	City:	State:	ZIP Code:		Employer phone #: ( )	
Occupation:	Employer:				Cell phone #: ( )	
Pharmacy: Address or Intersection:		Phone:				
Chose clinic because/Referred to clinic by (please check one):		❑ Dr.	❑ Billboard	❑ TV Commercial	❑ Internet	
❑ Family/Friend	❑ Close to home/work	❑ Yellow Pages	❑ Advertisement Where?	Other		
Other family members seen here:			**Email:**			
INSURANCE INFORMATION						
(Please give your insurance card and Driver's License to the receptionist)						
Person responsible for bill:	Birth date: / /	Address (if different):		Home phone no.: ( )		
Is this person a patient here? ❑ Yes ❑ No						
Occupation:	Employer:	Employer address:		Employer phone no.: ( )		
Is this patient covered by insurance? ❑ Yes ❑ No						
Please indicate primary insurance	❑ United Healthcare	❑ Aetna	❑ Blue Cross Blue Shield	❑ Humana	❑ Medicare	
❑ Cigna	❑ Great West	❑ AvMed	❑ Tricare	❑ Other		
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other		
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:		
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other		
IN CASE OF EMERGENCY						
Name of local friend or relative:	Relationship to patient:	Home phone #: ( )	Cell phone #: ( )			

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

PAST MEDICAL / SURGICAL HISTORY

NAME:_____ **DATE:**____/____/_____

HEIGHT:_____ **WEIGHT:**_____

NAME OF YOUR PRIMARY CARE PHYSICIAN_____

PHARMACY NAME / LOCATION:_____

REASON FOR VISIT:_____

WHEN DID SYMPTOMS OCCUR?_____

IS THIS VISIT DUE TO A WORK RELATED INCIDENT? ____YES ____NO

MARITAL STATUS: _____SINGLE _____MARRIED _____DIVORCED

DO YOU LIVE WITH ANYONE OTHER THAN YOURSELF: ____YES ____NO
IF YES: ____SPOUSE _____FAMILY ____ROOMATE

OCCUPATION:_____

DO YOU HAVE ALLERGIES TO ANY MEDICATIONS? _____YES ____NO
(IF YES PLEASE LIST MEDICATION AND REACTION)

ALLERGIES:

MEDICATION NAME	**REACTION**
_____	_____
_____	_____
_____	_____
_____	_____

PRESCRIPTION MEDICATIONS:

MEDICATION NAME	**DOSE** (mg)	**FREQUENCY**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient's Name:_____

*******Please check what DOES apply********

	YES	NO
IMMUNIZATIONS:		
Flu shot		
Last Tetanus shot		
SURGERIES:		
Appendectomy		
C-Section		
Gallbladder		
Heart By Pass		
Hysterectomy		
Orthopedic		
Stents		
Tonsils		
List OTHER surgeries below		
CANCER:		
Breast		
Colon		
Lung		
Ovaries		
Prostate		
Skin (Type)		
HEART:		
Angina		
Cholesterol		
Congestive Heart Failure		
Coronary Artery Disease		
Heart Attack		
High Blood Pressure		
Eye:		
Cataracts		
Glaucoma		
Genitourinary:		
Kidney Stones		
Renal Disease		
Sexually Transmitted Disease		
GI:		
Hepatitis		
Pancreatitis		
Reflux		
Ulcer		
Crohn's		
IBS		
Diverticulitis		
ENDOCRINE:		
Diabetes		
Thyroid		

	YES	NO
Are you pregnant?		
Last Menstrual Period		
Are you Menopausal?		
MEDICAL SERVICES/ IMPLANTS:		
AICD		
Ports		
Pacemaker		
Joint Replacement		
BONES:		
Arthritis		
Fibromyalgia		
Osteoporosis		
NEUROLOGICAL:		
Migraines		
Seizures		
Stroke		
TIA		
PSYCHIATRIC/ SOCIAL:		
Anxiety		
Bipolar		
Depression		
RESPIRATORY:		
Asthma		
Bronchitis		
COPD		
Pneumonia		
Tuberculosis		
OTHER:		
Sickle Cell		
AIDS		
Anemia		
HIV		
ALCOHOL USE:		
Frequency- (None/Daily/Social/Alcoholic)		
TOBACCO USE:		
Never/ Former/Current- How many?		
FAMILY MEDICAL HISTORY:		
(Relationship to You)		
Cancer/ Type		
Cholesterol		
Diabetes		
Heart Disease		
High Blood Pressure		
Respiratory Problems		
Stroke		

Worker's Comp Information

Patient's Name: _____

Date of Birth: _____

Date of Accident: _____

Date of Service: _____

Employer's Name:_____

Employer's Phone #:_____

Insurance Name: _____

Insurance Address: _____
_____
_____

Insurance Phone Number: _____

Adjuster's Name: _____

Adjuster's Phone #: _____

Policy Number: _____

Claim # (if available): _____

Additional notes or useful information:

**Please note that it is not a guarantee that health policy will pick up any remaining balance and patient may end up with a balance once accidental policy gets billed.