STATMED QUICK QUALITY URGENT CARE
REGISTRATION FORM

(Please Print)

Today's date:			Primary Care Dr.:			
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:		Birth date: / /	Subscriber's S.S. 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: ____/____/_____**

DOB: ____/____/_____ LAST 4 SSN: _____

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
IMMUNIZATIONS:	
Flu shot	
Last Tetanus shot	
SURGERIES:	
Appendectomy	
C-Section	
Gallbladder	
Heart Bypass	
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
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 #: _____

Fax Number #: _____

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.