



Urgent MedCare Clinic

4805 East Highway 37
Tuttle, Oklahoma 73089
405-381-9979
(Fax) 405-381-9130

Name - Last _____ First _____ M _____
MARITAL STATUS
 DOB _____ Gender M F Soc. Sec. # _____ - _____ - _____ S M W D Sep
 HOME PH _____ WK PH _____ CELL _____
 ADDRESS _____ CITY _____ ST _____ ZIP _____
 EMPLOYER _____ ADDRESS _____

PERSON RESPONSIBLE FOR BILL (IF OTHER THAN ABOVE)

Name - Last _____ First _____ M _____
MARITAL STATUS
 DOB _____ Gender M F Soc. Sec. # _____ - _____ - _____ S M W D Sep
 HOME PH _____ WK PH _____ CELL _____
 ADDRESS _____ CITY _____ ST _____ ZIP _____
 EMPLOYER _____ ADDRESS _____

PRIMARY EMERGENCY CONTACT INFORMATION

Name - Last _____ First _____ M _____
 RELATIONSHIP _____ PH #1 _____ PH#2 _____
 ADDRESS _____ CITY _____ ST _____ ZIP _____

By my signature below I hereby acknowledge and authorize the following:

- UrgentMed**Care** Clinic and/or their associates to treat the patient named above and agree to pay all fees and charges for such services on the day those services are rendered unless other arrangements have been agreed upon in advance.
- Receipt of notice of HIPPA Consent regulations and requirements, the privacy practices and standard authorization regulations, and the disclosure of protected health information in use by UrgentMed**Care** Clinic.
- Any payments or benefits due or paid by my insurance company or companies to be assigned to UrgentMed**Care** Clinic.
- UrgentMed**Care** Clinic to release medical information necessary for the payment of claims and also to any physician for the continuum of my medical treatment.
- I am responsible for all deductible and co-pays amounts and any/all services not covered by insurance.

PATIENT NAME (Please Print) _____
 PATIENT SIGNATURE _____ DATE _____

Please Complete Second Side

INSURANCE INFORMATION

PRIMARY INSURANCE:

Policy Holder
Name - Last _____ First _____ M _____

Policy Holder
DOB _____ Gender M F Policy Holder
Soc. Sec. # _____ - _____ - _____

Policy Holder
HOME PH _____ WK PH _____ CELL _____

Policy Holder
ADDRESS _____ CITY _____ ST _____ ZIP _____

Policy Holder
EMPLOYER _____ ADDRESS _____

NAME OF INSURANCE _____ **GROUP NUMBER** _____ **POLICY NUMBER** _____

SECONDARY INSURANCE:

Policy Holder
Name - Last _____ First _____ M _____

Policy Holder
DOB _____ Gender M F Policy Holder
Soc. Sec. # _____ - _____ - _____

Policy Holder
HOME PH _____ WK PH _____ CELL _____

Policy Holder
ADDRESS _____ CITY _____ ST _____ ZIP _____

Policy Holder
EMPLOYER _____ ADDRESS _____

NAME OF INSURANCE _____ **GROUP NUMBER** _____ **POLICY NUMBER** _____

Today's Date: _____

In order for us to provide the very best comprehensive medical care, please complete the following form as accurately as possible. Please provide answers in every area, even if "not applicable" is the answer. If you need additional space for some information, please use the back of the form and indicate which area you are referencing (i.e Meds or Allergies).

PERSONAL HISTORY

Name-Last _____ First _____ M _____

DOB _____ Gender: M F Race _____ Soc. Sec. # _____ - _____ - _____

Home PH _____ Cell PH _____

Address _____ City _____ ST _____ Zip _____

MEDICATIONS (Please include dosage, OTC, Vitamins, Herbals etc. and why you are taking):

1. _____ for _____

2. _____ for _____

3. _____ for _____

4. _____ for _____

5. _____ for _____

6. _____ for _____

ALLERGIES (List medications, foods or conditions; your reaction to the item(s) and what you did.)

1. _____ reaction _____

2. _____ reaction _____

3. _____ reaction _____

4. _____ reaction _____

Who is your current Primary Care Provider _____ PH# _____

Are you wanting to establish/transfer your care with us? Y N

Other PROVIDERS (physicians) you are currently seeing or have in the last five years and why:

1. _____ for _____

2. _____ for _____

CHRONIC MEDICAL PROBLEMS/CONDITIONS (Please list all you have been diagnosed with, even ones that you did or do not take medications for.):

- 1. _____ when _____
- 2. _____ when _____
- 3. _____ when _____
- 4. _____ when _____
- 5. _____ when _____
- 6. _____ when _____

PREVIOUS SURGERIES/HOSPITALIZATIONS:

- 1. _____ when _____
- 2. _____ when _____
- 3. _____ when _____
- 4. _____ when _____

FAMILY HISTORY (Please list MEDICAL CONDITIONS of immediate family members):

Mother: _____	Father: _____
_____	_____
Sister: _____	Brother: _____
_____	_____
Maternal Grandmother: _____	Maternal Grandfather: _____
_____	_____
Paternal Grandmother: _____	Paternal Grandfather: _____
_____	_____

PLEASE LIST the two (2) main reasons you want to be seen today?

- 1. _____
- 2. _____

SOCIAL HISTORY:

MARITAL STATUS

Occupation: _____ S M W D SEP How Long? _____

If disabled, please list reason _____ Date Started _____

Who do you live with? _____ Relationship _____

Academics: Grade completed _____ Degree _____

Smoking/Dipping (now) Y N How much: _____ How long: _____

Alcohol use (now): Y N In the past: Y N How much: _____ Number of years: _____

Any illicit (street) drug use (now): Y N In the past: Y N What type(s): _____

PEDIATRICS (Please complete if patient is a minor):

Who else lives in the house: _____ Relationship: _____
_____ Relationship: _____

Does anyone who comes in contact with the patient smoke: Y N Relationship _____

Parent(s) S M W D SEP Name of custodial parent _____

Is the child in daycare: Y N Birth Weight ____ lbs ____ ozs. Birth: Vaginal C-Section

Please list any/all complications: _____

FEMALES ONLY:

How many pregnancies: ____ How many living children: ____ Date last pap smear: _____

Result of pap smear: _____ Any abnormal pap smears in the past: Y N (Please explain)

List complications during pregnancy: _____

MISCELLANEOUS:

Last tetanus shot: _____ Last colonoscopy: _____

Other issues you believe your provider should be made aware of: _____

