Thank you for choosing our office. In order to serve you properly, we need the following information.
(PLEASE PRINT). All information will remain confidential.

PATIENT INFORMATION: Today's Date: _______ / ________ / 20_ _

Patient Name: ____ check one: ☐ Male ☐ Female

Social Security #: _________ - ________ - __________

DOB: ____ / ____ / ____ check one: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed ☐ Other

Address:____

City: ____ State: ____________________ Zip: ______________

Patient #: Home: _____________________________________ Cell: _________________________________

Insurance Name: ____Policy # _____________________________

Policyholder's Full Name: ____Relationship: _________________

DOB: _____ / _____ / _____ SSN: ____

Emergency Contact Name and # ____

How do you hear of us? ____

Reason for visit: ____

Primary Care Physician ___________________________________ Location: ___________________________

ALLERGIES: ____

I authorize treatment for myself/my child based on the information I have provided regarding my past/current medical conditions. I also authorize the release, based on HIPPA privacy Act, of any medical information concerning myself/my child healthcare, advice and treatment (medical care) provided only for the purpose evaluating/administering claims for insurance benefits/or continuity of care. I hereby authorize payment of insurance directly to the Provider. I also acknowledge billing my insurance is not a guarantee of payment and I am responsible for any amount not covered by my insurance company. I also release information to my employer concerning Workers Compensation Injury. Insurance deductibles and co-pays are due at the time of service.

____ Date: _______ / ________ / 20___

Signature of Patient/Guardian

____ Date: _______ / ________ / 20___

Witness

bucformpatientinfo071609

HEALTH HISTORY QUESTIONNAIRE

*(Please complete **ALL** information requested)*

PAST MEDICAL HISTORY:

❐	Measles	❐	Anemia	❐	High Blood Pressure
❐	Mumps	❐	Bladder Infection	❐	Asthma
❐	Chicken Pox	❐	Epilepsy	❐	Sexually Transmitted Infection
❐	Scarlet Fever	❐	Migraine Headaches	❐	Hepatitis
❐	Heart Disease	❐	Diabetes	❐	Kidney Disease
❐	AIDS or HIV	❐	Tuberculosis	❐	Arthritis
❐	Cancer	❐	Back Trouble	❐	Stroke

Other: ____

PREVIOUS HOSPITALIZATIONS/SURGERIES/SERIOUS ILLNESSES:

Description	Date	Hospital, City, State

PLEASE LIST ALL CURRENT MEDICATIONS:

____

____

____

PAST SOCIAL HISTORY:

Alcohol Use
__ Never __ Rarely __ Moderately __ Daily

Tobacco Use
__ Daily __ How many packs? __ Quit Date __ Age Started _ Never

Recreational DRUG USE? If yes, please give description:

____

____

PAST FAMILY MEDICAL HISTORY:

Relationship	Age	Disease(s)	If Deceased, Cause of Death
Father			
Mother			
Sibling			
Sibling			
Children			

PATIENT ACKNOWLDGE OF NOTICE OF PRIVACY PRACTICES

Date: ________________________

I, ________________________ acknowledge that I am aware Brunswick Urgent Care's Notice of Privacy Practices.

CONTACT INFORMATION
(Please circle one for each question)

May we call you at home?	❑ YES	❑ NO	Work?	❑ YES	❑ NO
May we leave a message at home?	❑ YES	❑ NO	Work?	❑ YES	❑ NO

May we discuss your health information with your:

Spouse?	❑ YES	❑ NO
Parent?	❑ YES	❑ NO

Your health information may consist of items such as diagnosis, treatments, labs, prescriptions and appointments.

____
Signature of Patient, Parent or Guardian