F. ILY URGENT CARE
A Professional Corporation

PATIENT INFORMATION

Last Name | First Name | Middle Name | Social Security Number

Birthdate | Age | Sex | Marital Status | Height | Weight

Address | Street | Apt # | City | State | Zip Code

Home Telephone | I.D. or Driver's Lic. # | Name of Guarantor if Minor

E-Mail:

Parent Social Security Number & Date of birth (If Minor)

PATIENT EMPLOYED BY:

Employer Name | Occupation | Work Telephone

Address | Street | City | State | Zip Code

INSURANCE INFORMATION:

Insurance Name | Telephone

Address | Street | City | State | Zip Code

Policy # | Group # | Cert. #

Name of Insured | Date of birth | Relationship to Patient

Work Related Injury | yes | No | Date of Injury

Employer Name at the Time of Injury | Telephone

Address | Street | City | State | Zip Code

REASON FOR VISIT

MEDICAL CONDITION

List any kind of allergies

Describe any Medical Condition

List all Medication you are taking

PAYMENT AUTHORIZATION:

I hereby authorize Family Urgent Care to furnish the necessary information for billing purposes. I direct the insurer to pay, directly to the physician, all benefits due to him as a result of this claim. Although covered by insurance, I am aware that I am responsible for all charges, including the balance remaining after payment of possible insurance A copy of this authorization will be as valid as the original to release any information necessary to process this claim.

Signature of Patient | Date

Authorization for Minors | Date

PATIENT PAIN DRAWING

Using the symbols below, mark the areas on your body where you feel the described sensations.

Aching/ Numbness/Pin & Needles/Burning/Stabbing/Other

^^^ === 000 xxx /// ●●●

Back

Pain in arm(s) compared with neck:

- ☐ Worse than
- ☐ Same as
- ☐ Less than

Front

Left Right Right Left

Pain in leg(s) compared with back:

- ☐ Worse than
- ☐ Same as
- ☐ Less than

Are you presently working? Yes__No__ Patient Phone #:____________

If working: Employer__________________Occupation:____________

I have disclosed all prior injuries, accidents and Orthopedic problems to the best of my recollection.

Patient Signature______________________________ Date____________