EXPECARE FAMILY CARE URGENT CARE OF TEXAS

Patient Information

First Name: _____ **Last Name:** _____ **DOB:** _____

Home Address: _____ **Apt#:** _____

City: _____ **State:** _____ **Zip:** _____ **Sex:** M/F **SSN:** _____

Home Phone #: _____ **Cell:** _____ **Work:** _____

Email Address: _____ **DL/ID #:** _____ **State:** _____

Preferred Pharmacy / Address or Crossroads: _____

Pharmacy Phone #: _____

_____

Race: Caucasian / African American / American Indian / Asian / Hawaiian / Pacific Islander / Other / Decline
Ethnicity: Hispanic; Latino / Not Hispanic; Latino / Decline **Preferred Language:** _____
Marital Status: Married Single Separated Divorced Widowed
Employment Status: Full-time Part-time Self-employed Unemployed Student Military (active /retired)
How did you hear about us? Google Phonebook Insurance Family / Friend Minute Clinic Sign
Doctor Referral: _____ **Other:** _____

Responsible Party (disregard if same as above)

First Name: _____ **Last Name:** _____ **DOB:** _____

Home Phone #: _____ **Cell:** _____ **Work:** _____

Relationship to Patient: _____

Emergency Contact

First Name: _____ **Last Name:** _____ **DOB:** _____

Home Phone #: _____ **Cell:** _____ **Work:** _____

Relationship to Patient: _____

Insurance

Primary Insurance Plan: _____

Policy Holder Name: _____ **DOB:** _____ **Employer:** _____

Secondary Insurance Plan: _____

Policy Holder Name: _____ **DOB:** _____ **Employer:** _____

The signature blow acknowledges the information given is true and accurate the best of my knowledge. All fees collected are an estimate based on the eligibility and coverage given from the insurance company at the time of service. Urgent Care of Texas will bill the insurance company based on the contracted and allowable rates of the policy's plan and adjust the balance accordingly. All financial differences will be bill the responsible party.

Signature of Patient or Guardian: _____ **Date:** _____

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ALLERGIES:

Are you allergic to any medications? ☐ **Yes** ☐ **No**

If yes, please list: _____ **Reaction?** _____

If yes, please list: _____ **Reaction?** _____

If yes, please list: _____ **Reaction?** _____

Are you allergic to latex products? ☐ **Yes** ☐ **No**

Are you allergic to adhesive? ☐ **Yes** ☐ **No**

Are you allergic to any foods/products? ☐ **Yes** ☐ **No**

If yes, please list: _____ **Reaction?** _____

If yes, please list: _____ **Reaction?** _____

If yes, please list: _____ **Reaction?** _____

CURRENT MEDICATIONS: (List all current medications, vitamins and/or supplements you use/take)

Medications/Supplements	Strength?	How often is it taken?	Total day supply?	Needs refill?
_____	_____	_____ Per _____	_____ Days	☐ **Yes** ☐ **No**
_____	_____	_____ Per _____	_____ Days	☐ **Yes** ☐ **No**
_____	_____	_____ Per _____	_____ Days	☐ **Yes** ☐ **No**
_____	_____	_____ Per _____	_____ Days	☐ **Yes** ☐ **No**
_____	_____	_____ Per _____	_____ Days	☐ **Yes** ☐ **No**

Social:

Tobacco? ☐ Never ☐ Former ☐ Current every day ☐ Current some days

If current, how much/often? _____ **Per** _____ **What Type:** _____

If former tobacco user, how long ago did you quit? _____

Alcohol? ☐ **Yes** ☐ **No** **If Yes, how much/often?** _____ **Per** _____ **What Type:** _____

Drugs? ☐ **Yes** ☐ **No** **If Yes, Please List:** _____

Any previous or current problems with addiction? ☐ **Yes** ☐ **No** **If Yes, What?** _____

OB/GYN: (Females only) **Male** ☐ **N/A**

First day of last menstrual cycle? ____/____/____

How is your menstrual cycle? ☐ **Regular** ☐ **Irregular**

Have you ever had any surgeries? ☐ **Yes** ☐ **No**

Currently pregnant? ☐ **Yes** ☐ **No** **If Yes, How Many Weeks?** _____ **Weeks**

Currently breastfeeding? ☐ **Yes** ☐ **No**

Current use of birth control? ☐ **Yes** ☐ **No** **If Yes, What Type?** _____ **Name?** _____

Have you had a hysterectomy? ☐ **Yes** ☐ **No** **If Yes,** ☐ **Total** ☐ **Partial**

Have you had a tubal ligation? ☐ **Yes** ☐ **No**

Any other female reproduction surgeries? ☐ **Yes** ☐ **No** **If Yes, Type?** _____

Most recent pap smear? ☐ **Normal** ☐ **Abnormal** ☐ **N/A** **When(Month/Year)?** ____/____

Most recent mammogram? ☐ **Normal** ☐ **Abnormal** ☐ **N/A** **When(Month/Year)?** ____/____

Signature of Patient or Guardian: _____ **Date:** _____

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NEW PATIENT MEDICAL HISTORY

(Please fill out BOTH pages of this form)

Name: _____ **Date Of Birth:** ____/____/____ **Sex:** ☐ **M** ☐ **F**

PAST MEDICAL HISTORY: (Check all that apply.)

Self	Mother	Father	Brother	Sister	
☐	☐	☐	☐	☐	**Alcohol / Drug Abuse (circle applicable)**
☐	☐	☐	☐	☐	**Allergies**
☐	☐	☐	☐	☐	**Anemia - Iron Deficiency**
☐	☐	☐	☐	☐	**Anxiety / Depression (circle applicable)**
☐	☐	☐	☐	☐	**Asthma**
☐	☐	☐	☐	☐	**Bipolar Disorder**
☐	☐	☐	☐	☐	**Cholesterol - High/Low (circle applicable)**
☐	☐	☐	☐	☐	**COPD**
☐	☐	☐	☐	☐	**Diabetes**
☐	☐	☐	☐	☐	**Epilepsy**
☐	☐	☐	☐	☐	**Hypertension**
☐	☐	☐	☐	☐	**Hypothyroidism / Hyperthyroidism (circle applicable)**
☐	☐	☐	☐	☐	**Mental Illness- If yes, type(s):** _____
☐	☐	☐	☐	☐	**Migraines**
☐	☐	☐	☐	☐	**Multiple Sclerosis**
☐	☐	☐	☐	☐	**Cancer If yes, type(s):** _____
☐	☐	☐	☐	☐	**Stroke-If yes, at what age?** _____
☐	☐	☐	☐	☐	**Heart Attack-If yes, at what age?** _____
☐	☐	☐	☐	☐	**Other:** _____

Mother ☐ Alive ☐ Deceased ☐ Unknown If deceased, reason for death? _____

Father ☐ Alive ☐ Deceased ☐ Unknown If deceased, reason for death? _____

Any recent hospitalizations within the past 6 months? ☐ **Yes** ☐ **No**
Any recent ER visits within the past 6 months? ☐ **Yes** ☐ **No**
If yes to either, when? _____ **Reason?** _____

If yes to either, do you have your discharge paperwork with you? ☐ **Yes** ☐ **No**
If yes to either, have you followed up with any doctors? ☐ **Yes** ☐ **No** ☐ **Not Yet, appt is:** ____/____/____
If yes to either, were you given prescriptions? ☐ **Yes** ☐ **No**
If yes, did you complete them? ☐ **Yes ☐ **No** ☐ **Not Yet**
**If yes, please list: Medication: _____ Strength: _____ Total day supply: _____ days
Medication: _____ Strength: _____ Total day supply: _____ days

PAST SURGICAL HISTORY:

Have you ever had any surgeries? ☐ **Yes** ☐ **No**
If yes, please list: Type: _____ Location: _____ Year: _____
Type: _____ Location: _____ Year: _____
Type: _____ Location: _____ Year: _____