

For Office Use Only

Rm _____
 Checkout? Yes No
 IN OUT PVP W/C
 Patient is:
 New Pt F/U Est Pt



For MA Use Only

Height _____ Weight _____
 Temp _____ Pulse _____
 BP _____/_____/_____ LMP _____
 Resp _____ Pul Ox _____

DEMOGRAPHIC INFORMATION

Name _____
Last First MI
 DOB ____/____/____ SSN ____-____-____
 Male Female, if you are female:
 Are you pregnant? No Yes
 Breast feeding? No Yes

REASON FOR VISIT TODAY

Reason for visit today _____

 This is a **follow up visit**: condition is: Better Worse Same
 Please explain: _____

 Symptoms Present for: _____ days weeks months
Is this a work comp injury/illness? No Yes

SOCIAL HISTORY

Marital Status: _____
 Occupation: _____
 Smoke? No Yes; _____ packs/day
 Alcohol? No Yes; _____ drinks/week

ALLERGIES

Medication Allergies No known drug allergies
Non-Drug Allergies No known allergies

CURRENT MEDICATIONS

PLEASE LIST PRIOR SURGERIES & MEDICAL PROBLEMS

PAST MEDICAL HISTORY/FAMILY HISTORY

	Yourself	Blood Relative
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer: _____	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Hayfever, allergies, hives	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
None of the above	<input type="checkbox"/>	<input type="checkbox"/>

PHYSICIAN INFORMATION

Do you want information sent to your physician regarding your treatment today? No Yes

If yes, _____
Name Phone Number

TREATMENT CONSENT AND AUTHORIZATION

I understand that the physicians at Urgent and Family Care are not prepared to treat chronic health needs. If I have any chronic health conditions Urgent and Family Care can treat this condition initially but it is important for me to establish care with a family practice physician. As a courtesy, Urgent and Family Care can provide a list of area practitioners at my request.

I have read the above information and consent that it is correct to the best of my knowledge. I authorize Urgent and Family Care at Avery Ranch, LLP and its healthcare providers to render necessary treatment for my condition.

Signature of Patient/Guardian _____ Date _____

Call back necessary in _____ days or _____ weeks.

For Physician
 Use Only

This form has been reviewed by the treating physician.
 Physician Signature _____