For Office Use Only

Rm _____
Checkout?
□ Yes
□ No

□ IN
□ OUT
□ PVP
□ W/C

Patient is:
□ **New Pt**
□ **F/U**
□ **Est Pt**

URGENT AND FAMILY CARE at Avery Ranch, LLP

For MA Use Only

Hx of Asthma	Y N	Hx of Bronchitis	Y N
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

ALLERGIES

Medication Allergies
□ No known drug allergies

_____
_____
_____
_____

Non-Drug Allergies
□ No known allergies

_____
_____
_____
_____

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

CURRENT MEDICATIONS

_____
_____
_____
_____

PLEASE LIST PRIOR SURGERIES & MEDICAL PROBLEMS

_____
_____
_____
_____

SOCIAL HISTORY

Marital Status: _____

Occupation: _____

Smoke? □ No □Yes; _____ packs/day

Alcohol? □ No □Yes; _____ drinks/week

PAST MEDICAL HISTORY/FAMILY HISTORY

	Yourself	Blood Relative
Arthritis	□	□
Cancer: _____	□	□
Diabetes	□	□
Hayfever, allergies, hives	□	□
Heart Disease	□	□
Thyroid Disease	□	□
None of the above	□	□

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 _____