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: ____________