

PLEASE COMPLETE ENTIRE FORM(S) CLEARLY TO ENSURE ACCURATE MEDICAL RECORDS

Preferred Pharmacy @ Street Intersection & City:

(Farmacia preferida con intersección de la calle y la ciudad) _____

How did you hear about us: Web Site M.D. Referral Drive/Walk by Flyer Friend/Family

(Como supiste de nosotros) (Sitio web) (Referido por doctor) (Desde el camino) (Folleto) (Amigo/Familia)

Insurance Work Internet/Yelp Other **Reason for Visit Today:**

(Aseguranza) (Trabajo) (Internet / Yelp) (Otro) (Razon de visita hoy) _____

PATIENT INFORMATION

Last Name:

(Apellido) _____

First Name:

(Nombre) _____

Initial:

(Inicial) _____

~If international traveler, please enter address of temporary residence

Date of Birth:

(Fecha de nacimiento) _____/_____/_____
Month/Mes Day/Dia Year/Año

Age / Edad: _____

Sex: M / F

(Sexo) Hombre/Mujer

Child /Single/ Married

Widowed / Divorced

Address:

(Domicilio) _____

Cell Phone: (_____) _____ - _____

(Telefono de celular)

City: _____

(Ciudad)

State: _____

(Estado)

Zip: _____

(Codigo postal)

Home Phone: (_____) _____ - _____

(Telefono de casa)

Email: _____

(Correo Electronico) @AOL.com @Hotmail.com @Gmail.com @MSN.com @Yahoo.com

Preferred Communication: (Comunicación preferida)

Email Cell Phone Home Phone Other (_____) _____ - _____

Check here if you are okay with us leaving a voice mail of your lab test results.

Marque aquí si está de acuerdo si dejemos un mensaje de llamada de los resultados de su laboratorio

In case of emergency, please contact /En caso de emergencia, póngase en contacto con

Name: _____ **Relation:** _____ **Phone:** (_____) _____ - _____

HEALTHCARE INSURANCE POLICY HOLDER INFORMATION

(Información de el suscriptor de seguro médico)

Name of Policy Holder: _____

(Nombre de asegurado principal)

Phone #: (_____) _____ - _____

(Numero de telefono)

Sex: M/F

(Sexo) Hombre/Mujer

DOB: _____/_____/_____
(Fecha de nacimiento)

Relationship to Patient / (Relación con el paciente)

Self Spouse Mother Father Guardian Life Partner Other
Yo Espos(a) Madre Padre Guardian Compañero de vida Otro

Address of Subscriber: _____

(Domicilio de el suscriptor de seguro médico)

City

State

Zip Code

Primary Care Physician Name: _____

(Nombre de doctor principal)

Physician's Phone # (_____) _____ - _____

(Numero de telefono de doctor)

PATIENT INFORMATION

NAME: _____ **DOB:** _____ **DATE:** _____

REASON FOR TODAY'S VISIT: _____

Welcome to Burbank Urgent Care Center, Our Commitment to you, our patients is to give you the highest quality care. In order to do that, we need your help. By answering the questions below, you will not only help yourself and your health care team, but increase the efficiency of our medical services. In all cases, be as complete as possible. If there are questions that are not clear to you, please bring them with your doctor or nurse.

MEDICATIONS: Please list your prescription and non-prescription medications (vitamins, home remedies, etc.)

Name of Medication	Dose	Frequency (how often)

ALLERGIES: Please list all to medicines, foods, etc.

Name of Allergies	Reaction

Are you? (Circle applicable): **Pregnant** **Breastfeeding**