Preferred Urgent Care
1450 W. Grand Parkway South
Suite M
Katy, TX 77494
281.916.1444

New Patient Registration Form

Patient Information

What's the reason for your visit today? _____

Name: _____
Last *First* *Middle Initial*

Date of Birth: _____ SSN: _____ ☐Male ☐Female

Parent/Guardian Name(s): _____
If Patient is a minor*

Address: _____ Cell: _____

_____ Home: _____

City: _____ State: ZIP: _____ Work: _____

*To gain access to your medical records online, please provide your email address: _____

I hereby permit the following means of communication related to my personal health, treatment, diagnosis, test results (including HIV), or billing as noted
☐ **All of following are acceptable** ☐ **Phone** ☐ **Text** ☐ **Voicemail** ☐ **Email** ☐ **Mail**.

Primary Care Doctor (PCP): _____ Phone #: _____

Address: _____ Fax #: _____

Pharmacy Name: _____ Phone #: _____

Address: _____ Fax#: _____

If you DO NOT authorize P.U.C. to release medical records (including HIV test results) to the PCP listed above, initial here: _____

How did you find us? ☐**PCP** ☐**Friend/Family**_____ ☐**Former patient** ☐**Google** ☐**Facebook** ☐**Yelp** ☐**Got to Run-Katy**
☐**Katy Magazine** ☐**Mann Eye** ☐**Insurance** ☐**ER:**_____ ☐**Retail clinic**_____ ☐**School:**_____
☐**Pharmacy:**_____ ☐**Other:**_____

Payment Information

☐ **Insurance Company** ☐ **No Insurance/Self pay (skip this section)**
(Please provide front desk with your insurance card and a valid ID)

☐ Aetna ☐ Blue Cross Blue Shield ☐ Cigna ☐ Humana ☐ United Healthcare (UHC) ☐ Medicaid ☐ Medicare
☐ Other Insurance: _____

Subscriber/Policyholder Information: ☐ **Self (skip this section)**
Subscriber Name: _____
Last, First, Middle Initial Relationship to Patient

☐ **Address is same as Patient's Address**
Address: _____

Date of Birth: _____ SSN: _____ ☐Male ☐Female

Demographic Information

Ethnicity/Race: ☐ Asian ☐ Black/African American ☐ Hispanic/Latino ☐ White/Caucasian ☐ Other: _____

HIPAA Authorization to Disclose and Emergency Contacts

It is the policy of Preferred Urgent Care not to release confidential medical information to patient's family members. We cannot discuss your medical condition, clinical diagnosis, or release medical test results to anyone without your consent.
I hereby give consent that my personal health information, treatment, diagnosis, test results, or billing information can be given to the following person(s):

_____
Name Phone # Relationship to Patient

_____
Name Phone # Relationship to Patient

☐ **Check here if you choose the same person(s) as your emergency contact.**

FLIP TO THE BACK PAGE

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DO NOT LEAVE IMCOMPLETE SECTIONS, Thank You

Patient Name (Last, First, MI) _____ **Date of birth** _____

Allergies

Initial: _____ If NO Allergies
Allergies (List all allergies and reaction to any medications, foods or agents):

_____

Medications

Initial: _____ If NO Medications **or** List all current medications, prescriptions or over the counter. Include their names, dosage, and frequency:

_____ _____

_____ _____

Medical History

Initial: _____ If NO Past Medical History
Select all diseases/conditions that you have or had:

☐ Anemia	☐ Depression/Anxiety	☐ High Blood Pressure	☐ Seizures/Epilepsy
☐ Arthritis	☐ GI Disorder	☐ Liver Disorder	☐ Sexually Transmitted Disease
☐ DVT/ PE	☐ Heart Disease	☐ Osteoporosis	☐ Thyroid Disorder (Hyperactive/Hypoactive)
☐ Diabetes (I/II)	☐ High Cholesterol	☐ Stroke	☐ Respiratory Disease (Asthma/Bronchitis/COPD)
☐ Other:			☐ Cancer _____

Surgical History

Initial:_____ If NO Surgical History List any surgeries you have had and the date (MM/YYYY):

_____ _____

Family History

Initial: _____ If NO Surgical History. Select diseases/conditions that a family has or had. Indicate the relative next to the condition: Mother(**M**) Father(**F**) Paternal Grandmother **(PGM**) Paternal Grandfather (**PGF**) Maternal Grandmother (**MGM**) Maternal Grandfather(**MGF**) Brother(**B**) Sister(**S**):
☐ **Unknown/Adopted** ☐ **No Significant Family History**

☐ Anemia	☐ Depression/Anxiety	☐ High Blood Pressure	☐ Seizures/Epilepsy
☐ Arthritis	☐ GI Disorder	☐ Liver Disorder	☐ Sexually Transmitted Disease
☐ DVT/ PE	☐ Heart Disease	☐ Osteoporosis	☐ Thyroid Disorder (Hyperactive/Hypoactive)
☐ Diabetes (I/II)	☐ High Cholesterol	☐ Stroke	☐ Respiratory Disease (Asthma/Bronchitis/COPD)
☐ Other:			☐ Cancer_____

Social History

Alcohol Use: ☐ None ☐ Daily ☐ Occasionally Number of Drinks: _____ (Daily/Weekly)

Tobacco Use: ☐ Never ☐ Past Use ☐ Presently Cigarettes per Day: _____ Number of Years: _____

Foreign Travel in the Past Year? ☐ Yes ☐ No Where? _____ When? _____

Tetanus Shot (Td): ☐ No ☐ Yes _____ (MM/YY) Flu Shot: ☐ No ☐ Yes _____ (MM/YY)

Consent for Treatment

I, the undersigned, consent to the care and the treatment by the attending physicians/mid-level providers, his/her associates or assistants and acknowledge that no guarantees have been made as to the effect of such treatment:

x _____
Signature of Patient or Authorized Representative *Print Patient's Name* *Date*

Notice of Privacy Practices, HIPAA Authorization to Disclose, Financial Policy, Consent for Treatment & E-Prescribe

I have reviewed the detailed Notice of Privacy Practice and other disclosures as provided at registration and understand that I may request a copy of the policy at any time.

x _____
Signature of Patient or Authorized Representative *Print Patient's Name* *Date*

NOTE: SIGNATURE IS REQUIRED