PATIENT REGISTRATION FORM

Name: ____ DOB: ______________ Age: _____ MALE FEMALE

Street Address ____

City: _____________________________ State: __________ Zip: _____________ SSN: _____-_____-_____

Marital Status ____________ Home Phone _______________________ Cell Phone _____________________

Email __________________________ Race: ___________ Language: ___________Ethnicity: ______________

Emergency Contact __________________ Phone: ________________ Relationship to You: _______________

*Do you authorize the release of any medical information? YES NO If yes, Name: ______________________

Preferred Pharmacy: ____

Pharmacy Address: ____

REASON FOR TODAY'S VISIT: ____

____

LIST ANY MEDICATION ALLERGIES YOU HAVE:

____

____

Please list all medications that you are currently taking, including over the counter medicines:

____

____

Primary Care Physician ____

Phone Number ______________________ City, State _________________________________

Insurance Carrier ____

Name Of Policy Holder If Not Self: _________________________________ D.O.B _________________

Current Pain Level (Please Circle) : 1 2 3 4 5 6 7 8 9 10

OCEAN STATE URGENT CARE

NEW PATIENT MEDICAL HISTORY

Please take a few minutes to answer the following questions so we may better assist your healthcare needs.

Name: ________________________________ **Today's Date: _______________**

Is Your Visit Related To An Accident? ______________ **Date Symptoms Began: ________________**

Do You or Have You Smoked? ________ **If Yes, When? ___________** **Cigarettes __ Pipe __ Other ______________**

ANY CHANCE OF PREGNANCY Y / N

PLEASE CHECK OFF THE FOLLOWING CONDITIONS YOU HAVE OR HAVE HAD IN THE PAST:

__ Heart attack
__ Shortness of Breath
__ Bowel/Bladder Problems
__Heart Palpitations
__ Asthma
__ Thyroid Problems
__ Angina
__ Chest Pain
__ Heartburn
__ Stroke
__ Headaches
__ Heart Murmur
__ High Cholesterol
__ History of Ulcers
__ Pacemaker
__ Joint pain/swelling
__ Trauma History
__ Diabetes
__ Fever
__ Anxiety
__ Loss of Appetite
__ Epilepsy/Seizures
__ Metal Implants/plates/screws
__ High Blood Pressure
__ Depression
__ Cancer
__ Osteoporosis

PLEASE CHECK OFF ANY OF THE FOLLOWING CONDITIONS YOUR FAMILY HAS OR HAS HAD IN THE PAST:

__ Heart attack
__ Shortness of Breath
__ Bowel/Bladder Problems
__Heart Palpitations
__ Asthma
__ Thyroid Problems
__ Angina
__ Chest Pain
__ Heartburn
__ Stroke
__ Headaches
__ Heart Murmur
__ High Cholesterol
__ History of Ulcers
__ Pacemaker
__ Joint pain/Swelling
__ Trauma History
__ Diabetes
__ Fever
__ Anxiety
__ Loss of Appetite
__ Epilepsy/Seizures
__ Metal Implants/plates/screws
__ High Blood Pressure
__ Depression
__ Cancer
__ Osteoporosis

PLEASE LIST ALL SURGERIES YOU HAVE HAD AND THEIR DATES:

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____

Patient Signature: ____ **Date: _______________________**

Provider Signature:____ **Date: _______________________**