

Plantation Urgent Care Center

901 S. State Rd.7 (441)* Plantation, FL 33317
Tel 954-797-2900 * Fax 954-792-4601

Confidential Patient Information

Date: _____

First Name: _____ Last Name: _____ Initial: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Work #: _____ Cell Phone#: _____

Social Security #: _____ Birth Date: _____ Age: _____ Sex: M F

Drivers License #: _____

Marital Status: S M D W Spouse's Name: _____ # of Children: _____

Occupation: _____ Employer's Name: _____

Work Address: _____

City: _____ State: _____ Zip Code: _____

How were you referred to Plantation Urgent Care Center: _____

Emergency Contact

First Name: _____ Last Name: _____

Relation: _____

Phone #: _____ Work #: _____

Insurance Information

Name of person responsible for payment: _____

Do you have Health Insurance? Yes No Insurance Company: _____

Address: _____

Insured's Name: _____ Insured's SS#: _____

Are you covered under any other group or individual health policy through yourself or your spouse?

Yes No Insurance Company: _____

Address: _____

Insured's Name: _____ Insured's SS#: _____

If this Injury/ Illness is related to an automobile accident. Please give the following Information:

Auto Insurance Co: _____ Agent's Name: _____

Policy #: _____ Claim #: _____ Phone #: _____

Address: _____

Major Complaint Information

What is your Major Complaint? _____ Date symptoms started: _____

What is the cause of this Injury? _____

What activities aggravate your condition? _____

Have you experienced these symptoms before? Yes No When? _____

Is this Injury/ Illness work-related? Yes No Have you reported it to your employer? Yes No

If so, when? _____

Have you seen a Doctor for this condition: Yes No Doctor's Name: _____

Date consulted: _____ Diagnosis: _____

Please list all Medications you are taking now? : _____

Are you allergic to any medications: Yes No Please List: _____

Do you have now, or have your ever had any Diseases or Medical Problems not listed below? Yes No
Please list: _____

Have you ever had any Surgeries or Hospitalizations? ? Yes No Please list type of
Hospitalization/ Surgery and Date(s): _____

If female, are you Pregnant? Yes No Due Date: _____

Additional Complaints

Please Check all that apply:

- | | | |
|--|--|---|
| <input type="radio"/> Headache | <input type="radio"/> Mid Back Pain/ Stiffness | <input type="radio"/> Flushed Face |
| <input type="radio"/> Concentration Loss | <input type="radio"/> Lower Back Pain/ Stiffness | <input type="radio"/> Excess Perspiration |
| <input type="radio"/> Eyes Sensitive to Light | <input type="radio"/> Right/ Left Shoulder Pain | <input type="radio"/> Digestive Trouble |
| <input type="radio"/> Memory Loss | <input type="radio"/> Right/ Left Arm Pain | <input type="radio"/> Nausea |
| <input type="radio"/> Heavy Feeling of Head | <input type="radio"/> Right/ Left Leg Pain | <input type="radio"/> Vomiting |
| <input type="radio"/> Dizziness | <input type="radio"/> Pins & Needles Arms/ Legs | <input type="radio"/> Diarrhea |
| <input type="radio"/> Ringing in Ears | <input type="radio"/> Vision Problems | <input type="radio"/> Constipation |
| <input type="radio"/> Loss of Balance | <input type="radio"/> Sinus Trouble | <input type="radio"/> Cold Hands |
| <input type="radio"/> Loss of Smell | <input type="radio"/> Nervousness | <input type="radio"/> Cold Feet |
| <input type="radio"/> Loss of Taste | <input type="radio"/> Chest Pain | <input type="radio"/> Jaw Pain |
| <input type="radio"/> Pain Behind Eyes | <input type="radio"/> Shortness of Breath | <input type="radio"/> Cancer |
| <input type="radio"/> Fainting | <input type="radio"/> Loss of Consciousness | <input type="radio"/> Hypertension |
| <input type="radio"/> Palpitation | <input type="radio"/> Irritable | <input type="radio"/> Diabetes |
| <input type="radio"/> Neck Pain | <input type="radio"/> Anxiety | <input type="radio"/> Hepatitis |
| <input type="radio"/> Neck Stiffness | <input type="radio"/> Depression | <input type="radio"/> Convulsions |
| <input type="radio"/> Neck Motion Restricted | <input type="radio"/> Insomnia | <input type="radio"/> Allergies |
| <input type="radio"/> Upper Back Pain/ Stiffness | <input type="radio"/> Fatigue | <input type="radio"/> Anemia |
| <input type="radio"/> Edema | <input type="radio"/> Heart Disease | <input type="radio"/> Arthritis |
| <input type="radio"/> HIV (Aids) | | |
| <input type="radio"/> Other: _____ | | |

I understand and agree that health and accident insurance policies are and arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fees or court costs if required to collect my bill.

I hereby authorize Plantation Urgent Care Center; physicians and staff to treat my condition as deemed appropriate. It is understood and agreed the amount paid the Doctor for X-Rays, is for examination only an the X-Rays negatives will remain the property of this office, being on file where they may be seen at any time. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions.

I certify that the above information is correct to the best of the best of my knowledge. I will not hold my doctor or nay members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature:

Date