BURBANK URGENT CARE
Burbank Occupational Health Center

REGISTRATION FORM (URGENT CARE)

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

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) (Rason de visita hoy) _____

PATIENT INFORMATION

SSN: _____/_____/_____ **DOB:** _____/_____/_____ **Age:** _____
(Numero de seguro social) (Fecha de nacimento) Month/Mes Day/Dia Year/Año (Edad)

Last Name: (Apellido) _____ **First Name:** (Nombre) _____ **Initial:** (Inicial) _____
~If international traveler, please enter address of temporary residence

Sex: M /F (Sexo) Hombre/Mujer Child / Single / Married Widowed / Divorced **Address:** (Domicilio) _____

Home Phone: ( ) _____-_____ **City:** _____ **State:** _____ **Zip:** _____
(Telefono de casa) (Ciudad) (Estado) (Codigo postal)

Cell Phone: ( ) _____-_____ **Email:** _____
(Telefono de celular) (Correo Electronico) @AOL.com @Hotmail.com @Gmail.com @MSN.com @Yahoo.com

Preferred Communication: (Comunicación preferida)
{ } Email { } Cell Phone { } Home Phone { } Other ( ) _____-_____

Race: { } American Indian { } Asian { } Black or African American { } Native Hawaiian or other Pacific { } White
(Raza) (Indio Americano) (Asiàtico) (Afro-Americano) (Nativo Hawaiano o otro Pacifico) (Blanco)

{ } Prefer not to state Ethnicity: { } Hispanic or Latino { } Non - Hispanic or Latino { } Language: _____

Preferred Pharmacy @ Street Intersection & City:
(Farmacia preferida con intersección de la calle y la ciudad**)** _____

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

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

HEALTHCARE INSURANCE SUBSCRIBER INFORMATION

(Información de el suscriptor de seguro médico)

Primary Healthcare Insurance Plan: PPO HMO EPO MEDICARE MEDI-CAL SELF PAY

Primary Care Physician Name: (Nombre de doctor principal) _____ **Physician's Phone #** ( ) _____-_____ (Numero de telefono de doctor)

Subscriber's Name: _____ **Phone #:** ( ) _____-_____
(Nombre de asegurado principal) (Numero de telefono)

Sex: M/F (Sexo) Hombre/Mujer **DOB:** _____/_____/_____ (Fecha de nacimiento)

Relationship to Patient / (Relación con el paciente)
Self (Yo) Spouse (Esposo(a)) Mother (Madre) Father (Padre) Guardian (Guardian) Life Partner (Compañero de vida) Other (Otro)

Address of Subscriber: _____
(Domicilio de el suscriptor de seguro médico) **City State Zip Code**

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PATIENT HEALTH INFORMATION
(PAST MEDICAL HISTORY FORM)

NAME (LAST, FIRST):_____ **DOB:** ____/____/____ **DATE:** ____/____/____

REASON FOR VISIT: _____

Pharmacy **RIGHT HANDED [ ]** **LAST**
@ Street & City_____ **LEFT HANDED [ ]** **TETANUS**____/____/____

We kindly ask you to complete this form as thoroughly as possible. If there are any questions that are not clear to you, please be sure to ask your healthcare team. Thank you.

YOUR HEALTH HISTORY

Medication / Vitamins List

Initial here if below is NOT APPLICABLE→

Medication / Vitamin Name	Dosage	How Often	Reason

***See reverse to write additional medications**

Allergies List

Initial here if below is NOT APPLICABLE→

I am allergic to	Reaction

Please mark ✓ if you have had:

Initial here if below is NOT APPLICABLE→

___Blood Clot (I82.403) ___Blood from rectum (K62.5) ___Diabetes Type I or II (E13)
___High cholesterol (E78.4) ___High blood pressure (I10) ___Migraine (G43) ___Seizures (G40.89)
___Stomach Ulcer (K27) ___Tuberculosis TB (A15.0) ___UTI (N39.0)

___Surgery (List procedures & year performed) _____

___Pregnancy (# of times & children)_____ Last menstrual period _____/_____/_____

Specify Problems with

Bladder_____ Heart_____ Lung_____

Kidney_____ Stomach_____ Other_____

Please mark ✓ if there is ***FAMILY HISTORY*** of diseases & indicate relationship with family member

___Asthma _____ ___Cancer_____ ___Diabetes_____

___Emphysema_____ ___High blood pressure_____ ___Heart Disease_____

___Kidney problems_____ ___Psychiatric problems_____ ___Stomach problems_____

___Stroke_____