WELCOME TO OUR PRACTICE

EXPEDIAN URGENT CARE™

Please take a few minutes to answer these questions so we can better assist with your health care needs.

PATIENT INFORMATION

Date _____ **SSN**_____**Birthdate**_____

Name _____ **Home Phone** (_____)_____

Address _____**Cell Phone** (_____) _____

May we contact you via text messages: Yes No

City _____ **State** _____ **Zip** _____ **Email** _____

Sex☐ M ☐ F **Marital Status**: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Ethnicity: ☐Hispanic/Latino ☐**NOT** Hispanic/Latino **Preferred language**:_____

Race: ☐White ☐Black or African American ☐American Indian or Alaska Native

☐Asian☐ Native Hawaiian or Other Pacific Islander

Employer _____ Business Phone(_____)_____

Work Address _____Occupation _____

How did you hear about us ?
☐Friends/Family☐ Drive-by/Walk-in☐Insurance☐Internet ☐Google☐Other _____

Insurance _____ Cardholder Name_____ ___Relation to cardholder _____

Guarantor Name_____Relation_____Phone (____)_____

Address:_____City_____State_____ZIP_____

Emergency Contact: _____Relation _____ Phone (____)_____

REASON FOR VISIT

Please list your present health concerns, problems or symptoms

_____

_____

Patient/Guardian Signature:_____ **Date** _____