Arrived:_____
Rec'd:_____
Roomed:_____
Notify:_____
Dr :_____

MRN:_____

Date:____/____/____

Staff Initials: _____

Health Express Urgent Care Centers

REGISTRATION FORM

(ESTABLISHED PATIENTS)

Patient Last Name:_____ **Patient First Name:** _____

SS#:_____ **Date of Birth:** _____

Street Address:_____

City:_____ **State:**_____ **Zip:**_____

Home Phone:_____ **Cell Phone:**_____ **Consent to text:** __ YES __ NO

E-mail Address:_____@_____

REASON FOR VISIT: _____

(*If you are having CHEST PAIN you will be advised to go to the nearest ER)*

If Injured, did this injury occur at work? ☐ **YES** ☐ **NO**

Pharmacy Name/Location (RX will be sent to this location):_____

_____

FOR CLINICAL STAFF USE ONLY

Possibility of pregnancy (if applicable) ☐ **YES** ☐ **NO**

Do you have allergies to any medications? ☐ **No**

☐ **Yes (please list):**_____

Do you have any medical conditions?

☐ **HIGH BLOOD PRESSURE** ☐ **CAD/HEART ATTACK** ☐ **ARTHRITIS** ☐ **Hyper/Hypo-THYROIDISM**

☐ **KIDNEY DISEASE** ☐ **ASTHMA/COPD** ☐ **DIABETES** ☐ **OTHER:**_____

Please list any medications you take regularly below (including over the counter medications and supplements):

1. _____ **Dose** _____ 4. _____ **Dose**_____
2. _____ **Dose** _____ 5. _____ **Dose**_____
3. _____ **Dose** _____ 6. _____ **Dose**_____

Hospitalization or Surgeries: _____

_____

_____

_____