VALLEY FORGE URGENT CARE & FAMILY MEDICAL CENTER

Patient Registration Form

TODAY'S DATE: ______________________ CHART #: ______________________

PATIENT INFORMATION

FULL NAME: ______________________________ (LAST / FIRST / MI)

SEX: M F MARITAL STATUS : S M D W

PERMANENT ADDRESS : ______________________________ (STREET / APT #)

______________________________ (CITY / STATE / ZIP)

BIRTHDATE: _______ / _______ / _________

DL # ____________________ AGE _________

SOCIAL SECURTIY: _______ - _______ - ________

TEMPORARY ADDRESS : ______________________________ (STREET / APT #)

______________________________ (CITY / STATE / ZIP)

HOME PHONE #: (_______) - _______ - ________

CELL PHONE #: (_______) - _______ - ________

E-MAIL ____________________ OCCUPATION ____________________

WORK PHONE #: (_______) - _______ - ________

EMPLOYER ______________________________

EMPLOYER ADDRESS: ______________________________ (STREET / SUITE / CITY / STATE / ZIP)

HOW DID YOU HEAR ABOUT US? ______________________________

IN CASE OF EMERGENCY, PLEASE NOTIFY: ______________________________

RELATION TO PATIENT: ____________________ EMERGENCY CONTACT PHONE #: ____________________

INSURANCE INFORMATION (INSURANCE CARD REQUIRED TO FILE INSURANCE CLAIMS)

PRIMARY INSURANCE: ______________________________

PT. RELATION TO INSURED: ________________

ADDRESS : ______________________________ (STREET)

______________________________ (CITY / STATE / ZIP)

INSURANCE PH. # (_______) - _______ - ________

EFFECTIVE FROM: ___________ TO __________

POLICY #: ______________________________

POLICY HOLDER'S NAME: ______________________________

GROUP #: ______________________________

POLICY HOLDER'S BIRTHDATE: _______ / _______ / _______

SOCIAL SECURTIY: _______ - _______ - ________

POLICY HOLDER'S EMPLOYER: ______________________________

WORK PHONE #: (_______) - _______ - ________

EMPLOYER ADDRESS: ______________________________ (STREET / SUITE / CITY / STATE / ZIP)

COPAYMENT $____________________ DEDUCTIBLE $____________________

ACKNOWLEDGEMENTS

I authorize my insurance benefits to be paid directly to the physician and I am financially responsible for all charges. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I agree to promptly pay for the services rendered for me or the patient named above. If I fail to meet my financial commitment to Valley Forge Urgent Care and it becomes necessary to take action to collect my account, I agree to pay all costs and expenses incurred in the collection of my account. I acknowledge that I have received a copy of VFUC's Notice of Privacy Practices – according to HIPAA Policy.

Patient Signature ______________________________ Date: ____________________

Health Maintenance Form

TODAY'S DATE: ______________________ CHART #: ______________________

PATIENT'S NAME ____

ALLERGIES

____

PAST MEDICAL HISTORY (DIAGNOSIS)

1 ______________________ 4 ______________________

2 ______________________ 5 ______________________

3 ______________________ 6 ______________________

HOSPITALIZATIONS

1 ______________________ 2 ______________________

ROUTINE HEALTH MAINTENANCE

Breast Exam				
PAP Smear/Pelvic				
Rectal/Prostate/PSA				
Mammogram				
EKG				
CBC/CMP/UA				
Stool For Blood				
Sigmoidoscopy				
Lipid Penel				
Visual Acuity				
Hearing Test				
DM Exam				

VACCINATIONS

Hepatitis B				
DTP or DTaP				
Influenza				
Polio				
MMR				
Varicella				
Meningititis				
Herpes Zoster				
HPV				
Tetanus (Td)				
Influenza				
Pneumovax				

MEDICATIONS

Drug	Dose/Freq	Start/DC	Drug	Dose/Freq	Start/DC

Health History Form

TODAY'S DATE: ______________________ CHART # (For Office Use Only):______________

FULL NAME ______________________ AGE ________ Date of Birth ______________

Check all items either Yes or No & give approximate date if past	No	Yes Now	Yes Past	Date	Check all items either Yes or No & give approximate date if past	No	Yes Now	Yes Past	Date
Alcoholism					Heart murmur as an adult				
Anemia (Type)					Hemorrhoids, rectal problems				
Angina / chest pain					Hepatitis (Type)				
Arteriosclerosis					Hernia				
Arthritis					High cholesterol/triglycerides				
Asthma / Hay fever					HIV / AIDS				
Blood Disease					Increased appetite/loss of appetite				
Blood Pressure High/Low					Irritable bowel syn: crohns/ulcer. colitis				
Injury to bone /tendon/ligament					Jaundice				
Cataracts					Kidney /kidney stones / bladder disease				
Chemical dependency					Migraine headaches/How frequent?				
Chemotherapy /radiation					Mitral valve prolapse				
Chronic bronchitis / emphysema					Night sweats				
Chronic liver disease					Poor blood clotting / bruising easy				
Colon, bowel trouble-diverticulitis/colitis					Psychiatric care				
Convulsions, seizures					Rheumatic fever				
Deafness / ringing ears / hearing aids					Sexually transmitted/venereal disease				
Diabetes					Shortness of breath				
Ear infections					Sinus trouble				
Enlarged heart					Skin disease / psoriasis / eczema				
Forgetfulness					Stroke/ CVA				
Glaucoma					Thirsty always/increased urination				
Gall stones					Thyroid problem				
Gout					Tuberculosis or positive T.B. test				
Head injury /concussion					Wakefulness, difficulty sleeping				
Heart attack					Weight loss or weight gain				

HABITS

DO YOU	Y	N	Daily Consumption
Smoke?	☐	☐	__________ Pkgs
Drink Coffee?	☐	☐	__________ Cups
Drink Alcohol?	☐	☐	__________ oz.
Drink Beer?	☐	☐	__________ oz.
Chew Tobacco?	☐	☐	__________
Exercise Regularly?	☐	☐	
Dieting?	☐	☐	
Use Drugs?	☐	☐	

Type ______________________

Use Drugs ______________________

MEDICATIONS

Please list all medications you are now taking, including those you buy without a doctor's prescription.

____

____

ALLERGIES

List anything that you are allergic to, such as medications, foods, etc.

____

____

IMMUNIZATIONS

☐ Tetanus Date: ________ ☐ Flu Date: ________ ☐ German Measles Date: ________ ☐ Pneumonia Date: ________

HOSPITALIZATIONS (Not including normal pregnancies)

OPERATION OR ILLNESS / PRIOR SURGERIES

____

____

____

SERIOUS ILLNESS NOT REQUIRING HOSPITALIZATION

ILLNESS YEAR

____

____

____

HAVE YOU HAD?

	Y	N	When/Since when?
Burning when urinating?	□	□	________
Blood in urine?	□	□	________
Loss of bladder control?	□	□	________
Blood in the stool/black stools?	□	□	________
Alternating diarrhea/constipation?	□	□	________
Pain during/after bowel movement?	□	□	________
Ribbon-like stools?	□	□	________
Require laxatives or enemas?	□	□	________
Pain in calves of legs when walking?	□	□	________
Pain in the big toe?	□	□	________

HAVE YOU HAD PAIN OR TIGHTNESS IN THE CHEST WHICH BEGINS:

	Y	N		Y	N
When exerting yourself?	□	□	Palpitations?	□	□
After a heavy meal?	□	□	Radiates down the arm?	□	□
When upset or excited?	□	□	Disappears if you rest?	□	□
When walking fast/uphill?	□	□			

Have you ever had swollen legs? Yes No

Do you use more than one pillow to sleep? Yes No

WOMEN ONLY

Last Pap smear _______ Last Menstrual period _______ Methods of Contraception ________________

□ Pregnancies # _______ □ Live Births # _______ □ Miscarriages or abortions # _______ □ Last Mammogram _______

□ Problems with menstrual periods □ Other gynecological problems □ Sexual difficulties □ Breast Cancer □ Ovarian cysts

MEN ONLY

□ Discharge from penis □ Pain in testicles □ Sexual difficulties □ Frequent urination at night

FAMILY HISTORY

Check condition(s) and relationships of any blood relative who has had any of the conditions listed.	Yes	No	Father	Mother	Brother	Sister	Son	Daughter	Check condition(s) and relationships of any blood relative who has had any of the conditions listed.	Yes	No	Father	Mother	Brother	Sister	Son	Daughter
Alcoholism									High blood pressure								
Allergies									Kidney disease								
Anemia									Leukemia								
Arthritis									Liver disease								
Asthma / hay fever									Mental illness								
Birth defects									Migraines								
Cancer									Nervous breakdown								
Colon / bowel trouble									Obesity								
Congenital heart defects									Rheumatic fever								
Diabetes									Sickle-cell anemia								
Emphysema									Stomach ulcer								
Epilepsy									Stroke								

I certify that the above information is correct to the best of my knowledge. I will not hold Valley Forge Urgent Care and Family Medical Center ot members of its staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature ______________________________ Date ________________