BURBANK URGENT CARE

REGISTRATION FORM (URGENT CARE)

*****PLEASE COMPLETE ENTIRE FORM(S) CLEARLY TO ENSURE ACCURATEMEDICAL RECORDS*****

Preferred Pharmacy @ Street Intersection & City:
(Farmaciapreferida conintersección de la calle y la ciudad) ____________________

How did you hear about us: (Como supiste de nosotros) **{ } Web Site** (Sitio web) **{ } M.D. Referral** (Referido por doctor) **{ } Drive/Walk by** (Desde el camino) **{ } Flyer** (Folleto) **{ } Friend/Family** (Amigo/Familia)
{ } Insurance (Aseguranza) **{ } Work** (Trabajo) **{ } Internet/Yelp** (Internet / Yelp) **{ } Other** (Otro) **Reason for Visit Today:** (Rason de visita hoy) ____________________

PATIENT INFORMATION

Last Name: (Apellido) ____________________ **First Name:** (Nombre) ____________________ **Initial:** (Inicial) ______

~If international traveler, please enter address of temporary residence

Date of Birth: ______/______/______
(Fecha de nacimento) Month/Mes Day/Dia Year/Año **Age / Edad:** ______

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

Cell Phone: ( ) ______-______ (Telefono de celular) **City:** ____________ (Ciudad) **State:** _____ (Estado) **Zip:** ______ (Codigo postal)

Home Phone: ( ) ______-______ (Telefono de casa) **Email:** ____________________
(Correo Electronico) @AOL.com @Hotmail.com @Gmail.com @MSN.com @Yahoo.com

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

{ } Check here if you are okay with us leaving a voice mail of your lab test results.
Marque aquí si está de acuerdo si dejemos un mensaje de llamada de los resultados de su laboratorio

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

Name: ____________________**Relation:** ____________ **Phone:**( ) ______-______

HEALTHCARE INSURANCE POLICY HOLDER INFORMATION

(Informacióndе el suscriptor de seguromédico)

Name of Policy Holder: ____________________ (Nombre de asegurado principal) **Phone #:** ( ) ______-______ (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 seguromédico) **City** **State** **Zip Code**

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

BURBANK URGENT CARE

PATIENT INFORMATION

NAME: ______________________________ **DOB:** ______________ **DATE:** ____________

REASON FOR TODAY'S VISIT: ____

Welcome to Burbank Urgent Care Center, Our Commitment to you, our patients is to give you the highest quality care. In order to do that, we need your help. By answering the questions below, you will not only help yourself and your health care team, but increase the efficiency of our medical services. In all cases, be as complete as possible. If there are questions that are not clear to you, please bring them with your doctor or nurse.

MEDICATIONS: Please list your prescription and non-prescription medications (vitamins, home remedies, etc.)

Name of Medication	Dose	Frequency (how often)

ALLERGIES: Please list all to medicines, foods, etc.

Name of Allergies	Reaction

Are you? (Circle applicable): **Pregnant** **Breastfeeding**