Urgent Care Form

Date: _____

Patient information	
Name:	**Date of birth:**
Address:	
Gender:	**Email:**
Contact number:	**Marital status:**
Emergency contact name:	
Relationship:	**Emergency contact number:**
Parent/guardian information (if under 18 or dependent)	
Name of parent/guardian:	
Relationship:	**Address:**
Email:	**Contact number:**
Insurance information	
Insurance provider:	**Policy number:**
Policyholder's name:	**Group number:**
Reason for visit	**Known allergies**
Current medications	**Chronic conditions or ongoing treatment**

Past medical history	Previous surgeries/hospitalizations

Family medical history

Lifestyle
Do you smoke, drink alcoholic beverages, or use any recreational drugs or non-prescribed medication? If yes, please specify and elaborate below.

Other relevant medical information

I've read the information above and answered it correctly to the best of my knowledge. I give my consent to receive medical treatment from the treating physician and authorize the release of medical information for insurance claims.

Signature of patient/guardian/patient	**Date**
Signature of treating physician	**Date**