2101 S. Loop 336 West, Suite 100 Conroe Texas 77304
Tel: 936.235.2825 ❖ Fax: 936.235.2826

PATIENT INFORMATION/DEMOGRAPHICS

Last name:	**First:**	**Middle:**	**Date of Birth:**	**Age:**
Address: City/State/Zip		**Social Security No.:**		
Home Phone:	**Cell Phone:**	**Marital Status:** ☐ Married ☐ Divorced ☐ Single		**Sex:** ☐ M ☐ F
Email:		**Primary Care Physician/Phone:**		
Employer: (Name and Address)		**Employer Phone:**		
In Case of Emergency: (Name of a local friend or relative)		**Relationship/Phone**		

How did you hear about us? ☐ Drive By ☐ Walk in/Location ☐ Internet ☐ Word of Mouth ☐ Family/Friend: ___________________________
☐ School Referral ☐ Advertisement ☐ Other: ____

FINANCIAL/INSURANCE INFORMATION

☐ I do not have health insurance will be responsible for services rendered at Family First Urgent Care

Insurance Name/Address/Phone:	Policy ID:	Group:
Policy Holder Name:	Policy Holder DOB:	Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐

Minor Consent (please check if applicable): I, __________________________________, being the parent or guardian of the above listed patient do hereby request and authorize Family First Urgent Care, its providers, affiliates and staff to perform medically necessary services including but not limited to x-rays, administration of medication and anesthetics which are deemed advisable by the provider. **Initial:** ___________________________

MEDICAL HISTORY

Reason for today's visit: Date of onset and current symptoms

Preferred Pharmacy: (Phone and Location)

Allergies: ☐ No known Allergies ☐ I am allergic to:	(Females) Are you pregnant? ☐ No ☐ Yes ___________weeks/months Date of last menstrual cycle: ______________________________________

Current Medications: Please list all prescriptions, non-prescriptions, vitamins, supplements dosages and how often

Current and Past Medical History:
☐ Headaches ☐ High Blood Pressure ☐ Arthritis ☐ Bone/Joint Disease ☐ Prostate Disease ☐ Gastritis/Ulcer ☐ Depression/Anxiety
☐ Diabetes ☐ Asthma/COPD ☐ Chest Pain ☐ Heart Disease ☐ Hepatitis ☐ Gout ☐ HIV
☐ Cancer (Type): ____ ☐ Other:____

Family History: (Check all that apply) ☐ Heart Disease ☐ Stroke ☐ Arthritis ☐ Osteoporosis ☐ Alzheimer's ☐ Gout ☐ Mental Illness
☐ Cancer (Type): ____ ☐ Other:____

Have you had surgery in the past? ☐ No ☐ Yes If yes, Type/Date:

Do you smoke/chew tobacco? ☐ No ☐ Yes _____Cigarettes _____Packs/Day _____Cigars ________Per Day

Do you use drugs? ☐ No ☐ Yes (if yes, how often & what)

Do you drink alcoholic beverages? ☐ No ☐ Yes ☐ Beer ☐ Wine ☐ Liquor If Yes, how often? ☐ Socially ☐ Rarely ☐ Daily

The above information is true to the best of my knowledge:

Patient Signature: ____ Date: ____________________________________