CONE HEALTH

Med Center Urgent Care Kernersville

How did you hear about us? _____

Name: _____ Age _____
Last Name First Name Middle Initial

Date of Birth: ____/____/____ Gender: ☐ Male ☐ Female SSN: _____

Home Address: _____
Street Address Apt # City/State/Zip

Mailing Address: (If different from above) _____
Street Address or PO Box City/State/Zip

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ Email: _____

Language: ☐ English ☐ Spanish ☐ Other _____ Needs interpreter: ☐ Yes ☐ No
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Race: ☐ Asian ☐ African American ☐ American Indian ☐ White ☐ Other ☐ Unknown

Emergency Contact Information

Name: _____
Last Name First Name Middle Initial

Home Address: _____
Street Address Apt # City/State/Zip

Relationship to Patient: _____ Home Phone: (_____) _____

Cell Phone: (_____) _____ Work Phone: (_____) _____

Patient Employment Information

Employer: _____ Occupation: _____

Check One: ☐ Full-Time ☐ Part-Time Work Phone: (_____) _____

Work Address: _____
Street Address City/State/Zip

Primary Insurance Information

Insurance Company: _____

Subscriber Name: _____

SSN# of Subscriber: _____ Date of Birth of Subscriber: ____/____/____

Patient Relationship to Subscriber: ☐ Self ☐ Child ☐ Guardian ☐ Other _____

Subscriber Address: _____
Street Address Apt # City/State/Zip

Policy #: _____ Group #: _____

CONE HEALTH

Urgent Care-Kernersville

Date: _____ Time: _____

Are you a new patient today? ☐ Yes ☐ No

Name_____ Age _____ Date of Birth _____ Gender you identify with: ☐ M ☐ F

Family Doctor _____ Is it ok to fax notes to your Family Doctor? ☐ Yes ☐ No

Allergies (food/medications) _____

Preferred Pharmacy (Name and Location) _____

Please list all of your medications (if you need more room, continue on the back of this form)

Medication	Dosage	# of times per day

Medical History (List all, ex.: Diabetes, High Blood Pressure, High Cholesterol, etc.)

_____

_____

All Females, Last Menstrual Period _____

Surgical History (List all regardless of date)

_____

_____

Family History (Please list any medical family history of your **mother, father** and **siblings**)

_____

_____

Social History

Do you smoke, vape or use e-cigarettes? ☐ Yes ☐ No If yes, how many packs per day? _____

If no, have you ever been a smoker? ☐ Yes ☐ No

Do you drink? ☐ Yes ☐ No If yes, how many drinks per week? _____

Do you use recreational drugs? ☐ Yes ☐ No Do you use smokeless tobacco (dip/snuff)? ☐ Yes ☐ No

What symptoms brought you in *TODAY* _____

_____

CLINICAL USE ONLY

Temp _____

HR _____

BP _____

RR _____

PO2 _____

Ht/Wt _____

Notes

_____

_____

_____

_____

_____

Travel out of US in last 21 days: ☐ Yes ☐ No Pain: _____