GB Urgent Care, PLLC

DEMOGRAPHICS

Name: ____ **Alias:** ______________________________
Date of birth: _____/_____/_______ **Sex:** ____________ **Home Phone:** _____-________-___________
SSN: ________________ **Address:** ____________________ **City, State, Zip:** ____________________
Temporary Address: ____
Email: ________________________________ **Language:** _____________ **Need Interpreter:** Yes/No
Ethnic group(Please select one): Hispanic Non-Hispanic Other (please specify): _________________
Patient Race: ___________

MyChart Access: MyChart is a patient portal that allows patients to obtain access to their medical history and patient chart from home. It is utilized within our office as well as a multitude of Hospitals we now provide this service to our patients. More information is available upon request.
Would you like to register for MyChart? Yes No

EMERGENCY CONTACTS

Name: ____ **Relationship to patient:** _________________
Home Phone: ____-_____-______ **Mobile Phone:** ____-_____-_____ Work **Phone:** ____-____-______
Legal Guardian: Yes / No **Address:** _____________________ **City, State, Zip:** _____________________
Impaired: Hearing / Visual / None **Notify on Admission:** Yes / No **Comments:**_____________________

Name: ____ **Relationship to patient:** _________________
Home Phone: ____-_____-______ **Mobile Phone:** ____-_____-_____ Work **Phone:** ____-____-______
Legal Guardian: Yes / No **Address:** _____________________ **City, State, Zip:** _____________________
Impaired: Hearing / Visual / None **Notify on Admission:** Yes / No **Comments:** ____________________

GUARANTOR INFORMATION *(Responsible Party/ Self if patient is 18+years)*

Name: ____ **Relationship to patient:** _________________

Date of birth: _____/_____/_______ **Sex:** ________________ **Account type:** _____________________

SSN: ________________ **Address:** ____________________ **City, State, Zip:** ____________________

Home Phone: ____-_____-______ **Mobile Phone:** ____-_____-_____ **Work Phone:** ____-____-______

Employer: ___________________ **Employment Status:** ___________ **Location:** ___________________

(Significant other)Name: _______________ **Date of birth:** ____/____/______ **SSN:** ____/___/_______

Primary Insurance: ____________________ **Policy Holder:** _______________

Signature: ___________________________ **Date:** ____/____/______

SOCIAL HISTORY

Does anyone smoke in the home? _Yes / No_ **Does the patient:** _Smoke / Use Recreational Drugs Alcohol *(amount)*_

Immunizations up to date: Yes No Unsure

Patients Last Menstrual Period (If applicable): ____/____/______ **Age of onset:** _____________

Have you had any of the following tests? (Please circle)

Ultrasound MRI CT UGI Hida Scan Swallow Study PH Probe Labs Other:_____________

Were the results: NORMAL or ABNORMAL **Location of test:** ___________________________

Have you seen any other specialists: ____

Do you have any allergies? Please list all known allergies.

_______________________________________ Reaction: _______________________________

_______________________________________ Reaction: _______________________________

Pharmacy Name: ____

Pharmacy Address: ____ **Phone Number**: _______________

Are you on any medications (including over the counter medications)?

Name of Medication:	Dosage	Times Given
______________________________	_______________________	_____________________
______________________________	_______________________	_____________________
______________________________	_______________________	_____________________

FAMILY MEDICAL HISTORY

Family Member	**Please list all medical conditions.**
Mother	
Maternal Grandmother	
Maternal Grandfather	
Maternal Aunt	
Maternal Uncle	
Father	
Paternal Grandmother	
Paternal Grandfather	
Paternal Aunt	
Paternal Uncle	
Sisters	
Brothers	
Other:	

PATIENT MEDICAL HISTORY (Alphabetical)

Diagnosis	Child	
	No	Yes
Anemia		
Asthma		
Attention Deficit Disorder (ADD/ADHD)		
Autism/Asperger/Autistic Spectrum		
Behavioral: Bipolar Disorder/ Anxiety/Depression/OCD		
Bleeding Disorders		
Blindness/ Visual Impairment		
Cancer		
Cerebral palsy		
Cystic Fibrosis/Urinary Disorders (Specify)		
Deafness/Hearing Impairment		
Developmental Delay : Learning/Speech/Motor/Cognitive/Speech delay		
Diabetes		
Failure to Thrive		
Febrile Seizure		
Gallstones		
GERD (Gastrointestinal Reflux Disease)		
Heart Disease: Cardiac Defect or Murmur		
Kidney Disease		
Known Genetic Disorder:		
Liver Disease		
Lymph Node Disorder		
Microcephaly (small head)		
Migraine Headaches		
Muscle disorder/dystrophy		
Scoliosis		
Seizure/ Epilepsy		
Sickle Cell Disease or Trait		
Sleep Apnea		
Thyroid Disorders		
Tuberous Sclerosis		
Other Illness/Serious Injuries: _____________________________________		

SURGICAL HISTORY

	Yes	No	Date		Yes	No	Date		Yes	No	Date
Adenoidectomy				**Fracture Surgery**				**ROP Surgery**			
Appendectomy				**Fundoplication**				**Gallbladder**			
Gastrostomy				**Tonsillectomy**				**Circumcision**			
Heart Surgery				**Tracheostomy**				**Cleft Lip**			
Hip Surgery				**Ear Tubes**				**Cleft Palate**			
Inguinal Hernia				**Umbilical Hernia**				**Cosmetic**			
Lymph node				**Dental/Restoration**				**PDA Repair**			
VP Shunt				**Orchiopexy**				**Rectal Biopsy**			
Abdominal:____ _____________				**Other:**							

I certify that all of the above information is correct to the best of my knowledge

Signature: ___________________________________ Date: ____/_____/______

Name (Print): ________________________________ Date:____/_____/______