DOCTORS' URGENT CARE
985 ROBERT BLVD, STE: 101
SLIDELL, LA 70458

Date: ______________

Account #: ____________

PATIENT MEDICATION/ALLERGY AND VISIT INFORMATION

Name: ____ Cell Phone: ____________________

Why are you being seen today? ____
Who is your Primary Care Physician?____
Have you been in close contact with somebody diagnosed or possibly having COVID19? YES NO
Is this a Motor vehicle accident?YES NO State of Accident:______
If yes, Date of Accident?______ Are you allergic to latex? YES NO
Is this a Work Related injury? YES NO Are you breastfeeding? YES NO
If yes, Date of Injury?________________ Are you possibly pregnant? YES NO
What Pharmacy do you want medications sent to? Name:____________________________________
Address:____ Phone Number:________________________

NOTICE: You are responsible for pharmacy availability and hours of operation.

VACCINES: Check one box for each vaccine:

Pneumonia	Influenza (Flu)	Tetanus	COVID-19
❑ Within past 5 years ❑ No ❑ Unknown	❑ Within the past year ❑ No ❑ Unknown	❑ Within the past 5 years ❑ No ❑ Unknown	❑ No ❑ Yes Date: ______________ Product: ____________

ALLERGIES: Are you allergic to medications, iodine, food or tape?

Allergy	Reaction	Allergy	Reaction

MEDICATIONS: Please list all prescription medication, over the counter medication, vitamin and nutritional supplements that you currently use.

Name of Medicine	Dose (Such as 50 mg)	Route (Oral, Drops, Inhalation, Injection, Skin or Spray)	Directions (How do you take it? Ex: 1 in a.m.)	Purpose? Why do you take it?	Taken Today? Check Box if yes.
					❑
					❑
					❑
					❑
					❑
					❑
					❑
					❑

EST/NEW **INS:**______________**/BENEFITS**__________________**BALANCE**_______ **CK IN PMNT**____________

Account #: ______________

DOCTORS URGENT CARE

PATIENT REGISTRATION FORM

Last Name: ______________________________ First Name: ____________________________ Middle Initial: _____

Date of Birth: ______________ SSN: ___________________ Birth Sex: **M F**

Street Address: ________________________ City: ____________________ State: _______ Zip Code: ________

Home Phone: ______________________ Cell Phone: _______________________ Other phone: __________________

Employer Name: ___________________________

Please Circle One

Language: English Spanish Other

Ethnicity: Hispanic or Latin Not Hispanic Decline to Specify

Race: **(W)** White / **(B)** African American / **(A)** Asian / **(A)** American Indian or Alaska Native / **(N)** Native Hawaiian or Pacific Islander / **(O)** Other or Multi-Racial / **(U)** Unknown / **(D)** Decline to Specify

IF PATIENT IS A MINOR PLEASE COMPLETE FOR RESPONSIBLE PARTY

Father Name:________________________________
Mailing Address: ____________________________
City/State/Zip:______________________________
Home Ph:_____________ Work Ph:______________
Cell Ph:______________ Date of Birth:__________
Social Security #:____________________________

Mother Name:________________________________
Mailing Address: ____________________________
City/State/Zip: ______________________________
Home Ph:_______________ Work Ph:____________
Cell Ph:____________ Date of Birth:_____________
Social Security #:____________________________

INSURANCE INFORMATION

PRIMARY INSURANCE

Ins Company: _______________________________
Relationship to Insured: Self Child Mate Other
Policy #:___________________________________
Policy Holder's Name:________________________
Policy Holder's SS #:_________________________
Policy Holder's DOB:_________________________

SECONDARY / SUPPLEMENTAL

Ins Company:________________________________
Relationship to Insured: Self Child Mate Other
Policy #:____________________________________
Policy Holder's Name:_________________________
Policy Holder's SS #:__________________________
Policy Holder's DOB:__________________________

I understand that current & valid insurance is necessary for reimbursement, unless I choose to pay for the service myself. This information, as well as personal mailing information, will be verified in writing and signed by the patient/responsible party before every office visit. I understand that having medical insurance does not release me from my financial liability to Doctors Urgent Care. It is ultimately my responsibility for payment of all charges for services rendered. This also includes workman's compensation patients. I authorize payment of medical benefits to Doctors Urgent Care.

Doctors Urgent Care reserves the right to turn over any patient balance due to an outside collection agency and or an attorney.
I further understand that a $25 fee will be charged for returned checks. This returned check and NSF fee must be paid in cash, credit card, or money order within 30 days of receipt of written notification from Doctors Urgent Care, LLC.

I acknowledge that I have the right to request a copy of the current HIPPA Privacy Notice effective 9-23-13 or later.

Signature of Patient/Responsible Party/Guardian: ______________________________________ Date: ______________