Brock Hughes Medical Center

Patient Registration Form: Urgent Care/Sports Physicals

First Name: _____

Middle Name: _____

Last Name: _____

Date of Birth: ____/_____/_____

Social Security #: _____/____/_____

Street Address: _____

City: _____

State & Zip Code: _____

Email Address: _____

Home Phone: _____

Cell Phone: _____

Occupation: _____

Gender: Male Female Choose not to Disclose

Ethnicity (select one):

____Hispanic ____Non-Hispanic

Marital Status: _____

Guarantor Information (If a Minor):

Name: _____

Date of Birth: _____

SSN: _____

Address: _____

_____

Are you a (circle one):

U.S. Citizen U.S. Resident Other

Are you a United States Veteran? Yes No

What is your primary language? _____

Do you require an interpreter? Yes No

Race (select all that apply):

____African-American ____Native American

____Asian ____Pacific Islander

____White ____ Hispanic

____Other

Emergency Contact:

Name: _____

Relationship to Patient: _____

Phone: _____

Preferred Pharmacy: _____

Preferred Method of Contact (circle):

Home Phone Cell Phone Text Message

Email

How did you hear about us:

_____

_____

Primary Insurance Company Information

Company: _____

Subscriber/Policy/Medicare/Medicaid Number:

_____

Group Number: _____

Primary Policy Holder Information

Policy Holder Name: _____

Policy Holder DOB: _____

Relationship to Patient: _____

No Insurance Coverage:

I currently do not have any medical insurance or pharmacy prescription coverage, whether through the government (Medicare or Medicaid), employment, or a private company. When I receive insurance coverage or pharmacy prescription coverage, I will notify Brock Hughes Clinic within 30 days of the start date of the new insurance and will provide a copy of my card.

Initial here: _____

By signing below, I am acknowledging that the above information is true and accurate to the best of my knowledge. I have had the opportunity to review the Notice of Privacy Practices. I also attest that if it is found that I am knowingly withholding insurance information and the time frame to file previous claims has been exceeded, I will be held responsible for any past due amounts. I am also acknowledging that I am not establishing care with BHMC, I am here for urgent care or a sports physical exam.

Signature of Patient or Legal Guardian: _____ Date: _____

Allergies

List ALL Medication Allergies

_____ _____ _____

_____ _____ _____

_____ _____ _____

List ALL Food Allergies

_____ _____ _____

_____ _____ _____

_____ _____ _____

List OTHER Allergies

_____ _____ _____

_____ _____ _____

_____ _____ _____

Current Medications & Health Issues

Attach a List of Current Medications (any prescriptions or over the counter medications, including vitamins, supplements, etc.) or list **ALL** current medications below:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

What health issues/conditions do you currently have? e.g. Diabetes, Hypertension, Heart Disease

_____ _____ _____

_____ _____ _____

List any recent hospitalizations. Include date(s) and reasons for hospitalization.

_____

_____

Signature: _____ Date: _____