Section 1—Demographic Information

Primary Care Physician:	Pharmacy: Location:

Name (Last, First, M.I.):	Nickname?:

Date of Birth: / /	Age:	Preferred gender: Male Female Transgender Other

Mailing Address:		
City:	State:	Zip Code:

Home Phone: ☐ Preferred	Work Phone: ☐ Preferred	Cell Phone: ☐ Preferred

E-mail Address: Employer: SSN:	**Do you have an Advance Directive in place? (Circle)** Advanced Directive POLST None

Primary Spoken Language:	To which racial or ethnic group(s) do you *most* identify:
English ☐	African-American (non-Hispanic) ☐
Spanish ☐	Asian/Pacific Islanders ☐
Portuguese ☐	Caucasian (non-Hispanic) ☐
Other: ☐	Latino or Hispanic ☐
	Native American or Aleut ☐
	Other: ☐

Section 2—Emergency Contact Information

Contact Name:	Relation to Patient:

Address:

Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )

Section 3—Insurance Information: if we have a copy of your Ins. card(s) skip this section

Primary Insurance:	Subscriber ID Number:	
Group Number:	Group Name:	
Complete the following questions if the subscriber is someone other than yourself, the patient.		
Subscriber's Name:	Subscriber's Date of Birth: / /	Relation to Patient:

Secondary Insurance:	Subscriber ID Number:	
Group Number:	Group Name:	
Complete the following questions if the subscriber is someone other than yourself, the patient.		
Subscriber's Name:	Subscriber's Date of Birth: / /	Relation to Patient:

Section 4—Consents

☐ I hereby certify that I am eligible for the health insurance plan I have listed in my registration form. I, also, certify that I have chosen The Priority Care Center to provide me with healthcare services. I understand that, were the aforementioned statement not true, I would be responsible for any and all charges for the services rendered. Additionally, I agree to pay all charges, in their entirety, and within 90 days of receiving an invoice for services rendered at the Priority Care Center.

☐ I understand my rights that are referenced in the notice of Privacy Practices (a copy of this can be made available to you upon request).

☐ I give consent to The Priority Care Center to obtain my prescription history.

☐ I give consent to contact me via Priority Care Center's secure patient portal.

Signature____ Date__________/__________/__________

Name______________________ Date: ________ DOB _________

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Current Medications/Supplements/Over the Counter

☐ Check this box if you will bring your medication bottles with you and skip to next section

Medication	Strength	How are you taking
Example: Tylenol	*Example: 500 mg*	*Example: 1 pill three times a day*

Past Medical History

Do you have any chronic conditions? If so, please describe: ____

____

Allergies

☐ No Known Allergies	☐ Medication Allergies	☐ Environmental/ Seasonal Allergies	☐ Latex Allergy

List Allergies	Reaction

Surgical History/Hospitalizations
Emergency Room Visits (within last 6 months)

Date	Reason or Procedure

Social History

Tobacco Use: Current use: ☐Yes ☐No
Marijuana Use: ☐Yes ☐No
Recreational Drug Use: ☐Yes ☐No
Alcohol Use: ☐Yes ☐No
Marital Status: ☐Married ☐Separated ☐Divorced ☐Domestic Partnership ☐Single ☐Widow/Widower
Living Situation: ☐Own ☐Rent ☐Homeless ☐Other ____
Support Network: ☐Spouse/Significant other ☐Family ☐Friends ☐Counselor ☐Other ____________________
Diet/Exercise: Are you on a special diet? ☐Yes ☐No if yes, what type ____________________________________

Name______________________ Date: ________ DOB _________

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HEALTH MAINTENANCE

Please provide the dates and results of the following immunizations, examinations, and tests to the best of your ability. If you have not had one of these services please indicate N/A (not applicable).

Health Maintenance			
Last Tetanus Booster	☐ Within past 10 years	☐ More than 10 years ago	☐ Unknown
If over 50: Last colonoscopy/ sigmoidoscopy/Or stool test	Date: _____________	☐ Normal ☐ Abnormal	☐ Unknown
If over 65, last Pneumonia Vaccine Flu shot this season?	Date: _____________ Date: _____________	☐ Normal ☐ Abnormal	☐ Unknown
Last labs done	Date: ______________	☐ Normal ☐ Abnormal	☐ Unknown
Females only:			
If over 21, last Pap Smear	Date: _____________	☐ Normal ☐ Abnormal	☐ Unknown ☐ N/A
If over 40, Last Mammogram	Date: _____________	☐ Normal ☐ Abnormal	☐ Unknown ☐ N/A

Reason for Visit/Concerns
Please indicate reason for visit regarding your health in the space provided:

____
____
____
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