Stony Creek URGENT CARE
Medical care when you need it.

Patient ID: # _____
Amount Paid: $ _____
Payment Type: _____
Initials (collected by): _____

PATIENT INFORMATION (please print)

Date _____ **REASON FOR VISIT** _____

How did you hear about us: _____

Social Sec. # _____ Date of Birth: _____ Gender M__F__

Last Name_____ M.I._____ First Name_____

Home Address_____ City_____ State_____ Zip_____

Billing Address (if different) _____

Please check one: Marital Status S___ M___ D___ W___ Other _____

PLEASE CIRCLE PRIMARY CONTACT NUMBER **May we contact you for follow up? Yes___ No___**

Home Phone _____ Cell Phone_____

E-mail Address_____

☐ Please check this box if you do not wish to receive non-medical information via e-mail.

EMERGENCY CONTACT_____ **Relationship** _____ **Phone**_____

Primary Care Physician _____ Phone # _____

Name of Physician Who Referred You Here _____ City/State _____

Employer_____ Work Phone _____

Employer Address_____ City_____ State_____ Zip_____

Optional:
Race _____ Ethnicity _____ Preferred Language _____

If Patient is under 18, the following information must be completed by the legal guardian accompanying them:

Name of Guardian _____ **Contact Number** _____

Address_____ City_____ State_____ Zip_____

Social Sec _____ DOB_____ Relationship _____

INSURANCE INFORMATION

PRIMARY INSURANCE_____

Member I.D. #_____ Group#_____

Ins. Policy Holder's Last Name_____ First _____ M.I._____

Date of Birth _____ Gender M__ F__ Relationship to Patient _____

SECONDARY INSURANCE_____

Member I.D. #_____ Group#_____

Ins. Policy Holder's Last Name_____ First _____ M.I._____

Date of Birth _____ Gender M__ F__ Relationship to Patient _____

OFFICE USE ONLY: Clinic: ☐ Branford ☐ Orange Revised 6/23/2017 Proofed by ☐ (initials)

Stony Creek URGENT CARE

Medical care when you need it.

Name: _____ Date: _____

Please answer "YES" or "NO" to each of the following symptoms related to TODAY'S VISIT ONLY.

		Yes	No		Yes	No		Yes	No
Constitutional	Change in appetite	☐	☐	Chills	☐	☐	Fatigue	☐	☐
	Fever	☐	☐	Sweats	☐	☐	Weight loss	☐	☐
Cardiovascular	Chest pain / pressure	☐	☐	Fainting	☐	☐	Flutter / palpitations	☐	☐
	Leg swelling	☐	☐						
Neurological	Headache	☐	☐	Light headedness	☐	☐	Loss of consciousness	☐	☐
	Numbness / tingling	☐	☐	Poor balance	☐	☐	Weakness	☐	☐
	Anxiety / nerves	☐	☐	Depression	☐	☐	Sleep difficulties	☐	☐
Lymph	Easy bleeding	☐	☐	Frequent infections	☐	☐	Nodes / glands	☐	☐
Eyes	Blurred vision	☐	☐	Contact lenses	☐	☐	Double vision	☐	☐
	Eye discharge	☐	☐	Eye pain	☐	☐	Eye redness	☐	☐
	Eye swelling	☐	☐	Eyeglasses	☐	☐			
ENT / Mouth	Difficulty swallowing	☐	☐	Dizziness	☐	☐	Ear pain	☐	☐
	Hoarseness	☐	☐	Mouth pain	☐	☐	Nasal congestion	☐	☐
	Nose discharge	☐	☐	Sore throat	☐	☐			
Respiratory	Congestion	☐	☐	Cough	☐	☐	Shortness of breath	☐	☐
	Snoring	☐	☐	Wheeze	☐	☐			
GI	Abdominal pain	☐	☐	Blood in stool	☐	☐	Constipation	☐	☐
	Diarrhea	☐	☐	Nausea	☐	☐	Rectal/Perirectal	☐	☐
	Urinary/bowel changes	☐	☐	Vomiting	☐	☐			
GU	Blood in urine	☐	☐	Discharge	☐	☐	Frequent urination	☐	☐
	Nighttime urination	☐	☐	Painful urination	☐	☐			
Musculoskeletal	Back pain	☐	☐	Joint pain	☐	☐	Muscle pain	☐	☐
	Swelling	☐	☐						
Skin	Bruising	☐	☐	Itching	☐	☐	Laceration	☐	☐
	Rash	☐	☐	Redness	☐	☐	Skin sores	☐	☐
Endocrine	Abnormal blood sugar	☐	☐	Cold intolerance	☐	☐	Excessive hunger/thirst	☐	☐
	Hair loss	☐	☐	Heat intolerance	☐	☐			
Allergy/Immune	Itchy eyes	☐	☐	Swelling Lips, Tongue, and/or Throat	☐	☐	Post-nasal drip	☐	☐
	Sneezing	☐	☐						