WellFast URGENT CARE CENTER

EAST
1902 East Gore Blvd.
Lawton, OK 73501

WEST
NW 67th St, Ste E
Lawton, OK 73501

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PATIENT REGISTRATION

Today's complaint: _____ Visit Date: _____

Patient

Last Name: _____ First Name: _____ Middle: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Preferred Message Phone: _____ SSN: ___/___/___
Date of Birth: ___/___/___ Age: _____ Marital Status: _____ Sex: _____
Employer: _____
Employer address/phone: _____
Email Address: _____ Would you like us to send informational emails? Y ☐ N ☐

RACE

American Indian or Alaska _____ Asian _____ White _____
Black or African American _____ Hawaiian or Pacific Islander _____ Hispanic or Latino _____
Not Hispanic or Latino _____

Preferred Language _____ Need Translation Y ☐ N ☐

Health Insurance

Primary Insurance: _____ Effective Date: ___/___/___
Group Number: _____ Subscriber Number: _____
Policy Holder Name: _____ Date of Birth: _____
Employer: _____ Relationship to Patient: _____
Insured SSN: _____
Secondary Insurance: _____ Effective Date: ___/___/___
Group Number: _____ Subscriber Number: _____
Policy Holder Name: _____ Date of Birth: ___/___/___
Employer: _____ Relationship to Patient: _____

Responsible Party

Last Name: _____ First Name: _____ Middle: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Preferred Message Phone: _____ SSN: ___/___/___
Date of Birth: ___/___/___ Marital Status: _____ Sex: _____
Employer: _____ Relationship to Patient: _____
Employer address/phone: _____

In Case of Emergency

Last Name: _____ First Name: _____
Address: _____ City/State: _____ Zip: _____
Relationship to Patient: _____ Phone Number: _____

Primary Physician

Personal Physician: _____ Phone Number: _____

Referred by: _____

How did you hear about us? ___Newspaper ___Friend/Co-worker ___Internet ___Yellow Pages ___Doctor___Billboard

Revised: 10/2/2012

Patient Health History Page 2

Medications and dosages: **(including over the counter)**	**Medication Allergies:**
1	
2	
3	
4	
5	
6	**Hospitalizations/Surgeries:**
7	
8	
Medical History/Injuries	

Immunizations: When did you last have?

Tetanus: _____ Flu: _____ Hep B: _____

IMMEDIATE Family History

(Check items that only apply to your IMMEDIATE family history)

Heart Failure (Weak Heart):			Thyroid Disease:	
High Blood Pressure (Hypertension):			Glaucoma:	
Heart Attack or Angina:			Osteoporosis:	
Stroke:			Migraine Headaches:	
High Cholesterol:			Depression:	
Diabetes:			Cancer:	
Emphysema:			Alcoholism:	
Asthma:			Trouble with blood not clotting:	

I hereby apply for treatment by the physicians of this practice and/or their assistants. I authorize the release of any information necessary for payment and to obtain reimbursement on any insurance claim. I request that payment of authorized benefits be made on my behalf and I assign benefits to which I am entitled to this practice. *I UNDERSTAND THAT PAYMENT IS DUE AT THE TIME OF SERVICE AND THAT* ***I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT PAID BY INSURANCE*** . In the event of default, I agree to pay all costs of collection, including reasonable attorney's fees. Photocopy of this agreement shall be as valid as the original.

_____ _____

SIGNATURE DATE

Save Print

revised 06/28/2007