PLEASE PRINT

EMERGENCY
PHYSICIANS MEDICAL CENTER
More than urgent care... your alternative to the ER

RETURN **Registration Form** **NEW**

Last Name:_____ First Name:_____ MI_____

Date of Birth:____/____/____ SSN: _____-____-_____ Gender:_____

Mailing Address:_____

City:_____ State:___ Zip:_____ Email Address:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Is it ok to leave a message at the contact number listed? Y / N

Permission to leave any test results on your voicemail? Y / N [ ]Home or [ ]Cell

Is this visit Workers Comp? Y / N, Is this visit Motor Vehicle Accident (MVA)? Y / N

Primary care Physician Name:_____ Phone Number:_____

Insurance Company Name:_____ Policy Holder Name:_____

Member ID:_____ Policy Holder DOB: _____/_____/_____

Address_____

What pharmacy will you be using today? Name:_____ Location:_____

Emergency Contact Name:_____ Phone Number:_____

It is ok to release my health information to the following:

Name:_____ Relationship:_____

How did you hear about Emergency Physicians Medical Center?:_____

Please return this to the front desk when completed with the following:

- **Drivers License**
- **Insurance card(s)**
- **Please ask for/read the laminated forms regarding HIPAA and insurance**
- **You will be responsible for all applicable copays, coinsurance, and/or deductibles today**

I hereby authorize EPMC to release pertinent visit information to my PCP and insurance/financial institutions for payment. I authorize EPMC to medically treat me as well as obtain x-rays, labs, IV's as needed for treatment. I understand that I am financially responsible for any charges and agree to pay them in full.

Please Sign Here: Name_____ Date_____

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Reason for Visit:

_____

_____

Medications:

Name: **Dose:** **X per day:** **Reason for Rx:**

_____

_____

_____

Drug Allergies: **Reaction:**

_____

_____

_____

Medical Hx: (Circle all that apply)

Diabetes Diabetes II Hypertension

Asthma COPD Stroke Heart Attack

Other:_____

Surgical Hx (circle all that apply):

Appendectomy Gallbladder

Hysterectomy Tonsillectomy

Other:_____

Circle One:

Never Smoked Current Smoker Former Smoker If yes, how much?_____

Year started:_____ **Year quit:**_____ **Do you want to quit?** Y / N

Do you drink? Yes Socially No

Family History of: Hypertension Diabetes I/II Other:_____

Have you had a Tetanus shot within the last 5 years? Y / N

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For Staff Use ONLY

BP_____ Pain_____

Pulse_____ Weight_____

RESP_____ Height_____

TEMP_____

02SAT_____