PATIENT'S NAME: ____ **TODAY'S DATE**:____________________

DATE OF BIRTH:___________________ **SOCIAL SECURITY NUMBER**:_____________________ GENDER: ☐ M ☐ F

ADDRESS:____ CITY:_________________________________

STATE:________ ZIP: __________________ EMAIL:____

PHONE NUMBER(S): CELL:____________________________________ HOME:________________________________

PRIMARY CARE PHYSICIAN: ____________________________________PHONE: _______________________________

INSURANCE:____ ID NUMBER:_____________________

POLICY HOLDER NAME:____

SUBSCRIBER NAME:____ SUBSCRIBER DOB:_____________________

INSURANCE:____ ID NUMBER:_____________________

POLICY HOLDER NAME:____

SUBSCRIBER NAME:____ SUBSCRIBER DOB:_____________________

EMERGENCY CONTACT:____ PHONE:______________________________

RELATIONSHIP: ____

PHARMACY:____ PHONE:______________________________

I authorize Castle Pines Family Practice and Urgent Care to release any medical information required during the course of examination and treatment. Furthermore, I permit payment directly to them any benefits due for their services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes but is not limited to co-insurance, co-payment, deductible and non-covered services.

SIGNATURE:____ TODAY'S DATE:___________________

PATIENT'S NAME: ____ **DATE OF BIRTH**:___________________

REASON FOR TODAY'S URGENT CARE VISIT:

____

____

CURRENT MEDICATIONS ☐ None *PLEASE INCLUDE DOSAGE AND FRQUENCY OF USE:

____ ____

____ ____

____ ____

ALLERGIES TO MEDICATIONS ☐ None *PLEASE INCLUDE REACTIONS TO MEDICATIONS:

____

____

MEDICAL HISTORY ☐ None *PLEASE CIRCLE ANY OF THE FOLLOWING MEDICAL CONDITIONS FOR WHICH YOU ARE CURRENTLY BEING TREATED OR HAVE BEEN TREATED IN THE PAST:

Heart Disease	Diabetes	Stroke	Kidney Disease
High Blood Pressure	Asthma	Cancer	Seizure
High Cholesterol	Blood Clots	Thyroid Disorder	Blood Disorders

Other:____

SURGICAL HISTORY ☐ None *PLEASE LIST ANY SURGERIES YOU HAVE HAD:

____

____

____

FAMILY HISTORY ☐ None in immediate family members ☐ Unknown (Adopted)

*PLEASE CIRCLE ANY OF THE FOLLOWING MEDICAL CONDITIONS THAT RUN IN YOUR FAMILY:

Heart Disease	Diabetes	Stroke	Kidney Disease
High Blood Pressure	Asthma	Cancer	Seizure
High Cholesterol	Blood Clots	Thyroid Disorder	Blood Disorders

Other:____

Do you currently use tobacco/nicotine? ☐ Yes - __________packs/cartridges/cans per day ☐ No

*If no, have you in the past? ☐ Yes ☐ No

Do you currently drink alcohol? ☐ Yes - _______drinks per day/week ☐ No INITIALS:____________