***Please provide our office staff with your insurance card and photo ID so that we may scan into our system.**

Patient Name: ______________________________ Sex: _____ Date of Birth: ____________________

Home Address: ____
City State Zip

Home Number: ________________ Work Number: _______________ Cell Number: _________________

Social Security Number: _______________________ Employer: ___________________________________

Marital Status: ___________________ Email Address: ____

Pharmacy Name: ___________________________________ Location: _____________________________

How did you hear about Community Quick Care? ____

INSURANCE INFORMATION

Primary Insurance Company: __________________ ID #: __________________ Group #: ______________

Subscriber's Name: _____________________________________ Subscriber's DOB: __________________

Second Insurance Company: __________________ ID #: __________________ Group #: ______________

Subscriber's Name: _____________________________________ Subscriber's DOB: __________________

VERBAL CONSENT

These individuals may receive verbal information about my chart or speak to our office staff on my behalf:

Name: ___________________________ Date of Birth: _____________ Relationship: _____________
Name: ___________________________ Date of Birth: _____________ Relationship: _____________

EMERGENCY CONTACT

Name: _________________________ Relationship: ________________ Phone: ____________________

Home Address: ____
City State Zip

Your signature on this form authorized us to receive payment and release medical information to your health insurance company. All other releases of medical records require additional authorization. Should our office have a need to leave a message on your cell concerning your appointment, your signature on this form gives us that permission. Your signature also indicates that you have received a copy of the HIPPA regulations (if requested), and you are giving us consent to treat you for your medical conditions.

____ ________________________
PATIENT'S SIGNATURE **DATE**

Adult History Questionnaire

Patient Name: ____

Date of Birth: _____/_____/_____ Age: _______ M / F________

Medications

Please list all medications below:

Name of medication	Dosage	Frequency	Reason for Medication

General

Do you consider yourself to be in good health? ______ Yes ______ No Explain: ______________________________

Do you have a serious illness or medical condition? ______ Yes ______ No Explain: ______________________________

Have you had any serious injuries or accidents? ______ Yes ______ No Explain: ______________________________

Have you had any surgeries? ______ Yes ______ No Explain: ______________________________

Have you ever been hospitalized? ______ Yes ______ No Explain: ______________________________

Are you allergic to any medicines or drugs? ______ Yes ______ No Explain: ______________________________

Family History

Have any family members had the following:

Deafness:	_____ Yes	_____ No	Who ______________	Comments ______________
Nasal Allergies	_____ Yes	_____ No	Who ______________	Comments ______________
Asthma	_____ Yes	_____ No	Who ______________	Comments ______________
Tuberculosis	_____ Yes	_____ No	Who ______________	Comments ______________
Heart Disease (before 50 years old)	_____ Yes	_____ No	Who ______________	Comments ______________
High Blood Pressure (before 50 years old)	_____ Yes	_____ No	Who ______________	Comments ______________
High Cholesterol	_____ Yes	_____ No	Who ______________	Comments ______________
Anemia	_____ Yes	_____ No	Who ______________	Comments ______________
Bleeding disorder	_____ Yes	_____ No	Who ______________	Comments ______________
Liver Disease	_____ Yes	_____ No	Who ______________	Comments ______________
Kidney Disease	_____ Yes	_____ No	Who ______________	Comments ______________
Diabetes (before 50 years old)	_____ Yes	_____ No	Who ______________	Comments ______________
Epilepsy or convulsions	_____ Yes	_____ No	Who ______________	Comments ______________
Alcohol abuse	_____ Yes	_____ No	Who ______________	Comments ______________
Drug Abuse	_____ Yes	_____ No	Who ______________	Comments ______________
Mental Illness	_____ Yes	_____ No	Who ______________	Comments ______________
Mental Retardation	_____ Yes	_____ No	Who ______________	Comments ______________
Immune Problems, HIV, or AIDS	_____ Yes	_____ No	Who ______________	Comments ______________
Cancer	_____ Yes	_____ No	Who ______________	Comments ______________
Sickle Cell Disease	_____ Yes	_____ No	Who ______________	Comments ______________

Additional family history ____

____

Adult History Questionnaire Cont:

Patient Name: ____

Birth Date: _____/_____/_____ Age: _____ M / F _____

____

Past History

Do you have, or ever had:

Chickenpox	_____ Yes	_____ No	When ____
Frequent ear infections	_____ Yes	_____ No	Explain ____
Problems with ears or hearing	_____ Yes	_____ No	Explain ____
Nasal allergies	_____ Yes	_____ No	Explain ____
Problems with eyes or vision	_____ Yes	_____ No	Explain ____
Asthma, bronchitis, or pneumonia	_____ Yes	_____ No	Explain ____
Any heart problem or heart murmur	_____ Yes	_____ No	Explain ____
Anemia or bleeding problem	_____ Yes	_____ No	Explain ____
Blood transfusion	_____ Yes	_____ No	Explain ____
Frequent abdominal pain	_____ Yes	_____ No	Explain ____
Constipation requiring doctors visits	_____ Yes	_____ No	Explain ____
Bladder or kidney infection	_____ Yes	_____ No	Explain ____
Any chronic or recurrent skin problem (acne, eczema, etc.)	_____ Yes	_____ No	Explain ____
Frequent headaches	_____ Yes	_____ No	Explain ____
Convulsions or other neurologic problem	_____ Yes	_____ No	Explain ____
Diabetes	_____ Yes	_____ No	Explain ____
Thyroid or other endocrine problem	_____ Yes	_____ No	Explain ____
Any other significant problem	_____ Yes	_____ No	Explain ____
Use of alcohol or drugs	_____ Yes	_____ No	Explain ____

Family and Social History

Please circle one for each family member:

Father	Alive	Deceased	Unknown	
Mother	Alive	Deceased	Unknown	
Siblings	Alive	Deceased	Unknown	N/A

Please circle only one per line:

Water in home	Bottled water	City Water	Well water	Spring Water
Smoking	Yes	No	Details: ______________________	
Home Type	Mobile home	Apartment	House	Duplex
Pets at Home	Indoors	Outdoors	None at Home	
Home Heat type	Forced Air	Baseboards		
Home Mold/Mildew	Yes	No		
Alcohol/ Drugs	Yes	No	Details: ______________________	
Sexually Active	Yes	No		
Traveled outside US	Yes	No	Details: ______________________	