URGENT CARE
of Berwick

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Savannah, Georgia 31405
(P) 912.201.1140 (F) 912.777.6449

PATIENT INFORMATION

Today's Date: _____ Gender: _____ Date of Birth: _____/_____/_____ Age: _____

Last Name: _____ First Name: _____MI: _____

SSN# _____--_____--_____ E--mail Address: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home #: (_____) _____--_____ Work #: (_____) _____--_____ Cell # : (_____) _____--_____

Employer:_____

Race/Ethnicity _____ Preferred Language: _____

Marital Status: (Circle) Single Married Divorce Separated Partnered Widowed

Emergency Contact: _____ Relationship to Patient: _____

Emergency Contact Phone #: _____

INSURANCE INFORMATION

Primary Insurance: _____

Subscriber's Name: _____

Subscriber's Date of Birth: _____/_____/_____

Subscriber's SSN : _____--_____--_____

ID #: _____

Group #: _____

Secondary Insurance: _____

Subscriber's Name: _____

Subscriber's Date of Birth: _____/_____/_____

Subscriber's SSN: _____--_____--_____

ID #: _____

Group #: _____

Reason for today's visit: _____

If Injured: Where you injured on the job? (Circle) Yes No Injury Date: _____

I authorize treatment and the release of medical information acquitted in my treatment to process claims to my insurance company. I authorize direct payment from my insurance company to Urgent Care of Berwick. 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. I understand that payment in full will be required at the time of service if I decided I want to file my own claim. I have received a Notice of Privacy Practices from Urgent Care of Berwick.

Signature of Responsible Party: _____ Date: _____/_____/_____

SURGERY/HOSPITALIZATIONS

1. Have you every had surgery? ☐ Yes ☐ No

2. Please list approximate dates and reasons for any surgery or other conditions (including childbirth) that required hospitalizations: ***(a separate list may be provided)***

Date	Reason for hospital stay
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

FOR OFFICE USE

SOCIAL HISTORY

Work Status

1. Employment/Work (Job/School/Play)
   ☐ Working Full-Time ☐ Working Part-Time
   ☐ Regular Duty ☐ Light Duty

2. Occupation: _____
   ☐ Student ☐ Retired ☐ Unemployed ☐ Disabled

Cultural/Religious

1. Are there any customs or religious beliefs or wishes that might affect your care? ☐ Yes ☐ No
   a. Please Explain: _____

Social/Health Habits

1. Smoking
   a. Do you currently use tobacco products? ☐ Yes ☐ No
   If yes: ☐ Cigarettes ☐ Cigars/Pipes ☐ Smokeless
   How many packs/day: _____
   If no: Have you used tobacco in the past? ☐ Yes ☐ No
   Year Quit: _____

2. Alcohol
   a. How many days per week do you drink beer, wine other alcoholic beverages? _____
   b. If 1 beer, 1 glass of wine or 1 cocktail equals 1 drink, how many drinks do you have in an average week? _____

3. Caffeine
   a. How much caffeinated coffee or caffeine containing beverages do you drink per day? _____

4. Exercise
   a. Do you exercise regularly
   ☐ Yes ☐ No Type: _____
   b. On average, how many days per week do you exercise?
   _____
   c. For how many minutes, on an average day?
   _____

5. General Health Status. Please rate your health:
   ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Living Environment

1. With whom do you live?
   ☐ Alone ☐ Spouse only
   ☐ Spouse and others ☐ Child (not spouse)
   ☐ Other relative(s) ☐ Group Setting
   ☐ Personal Care Attendant
   ☐ Other:_____

Other

1. Primary Language:
   ☐ English ☐ Other:_____
   Do you need an interpreter? ☐ Yes ☐ No

2. Learning Barriers
   ☐ None ☐ Vision
   ☐ Hearing ☐ Unable to read
   ☐ Unable to understand what is read
   ☐ Other:_____

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Patient/Guardian Signature: _____ Date: _____/_____/_____

Reviewed By: _____ License #: _____Date: _____/_____/_____

CHECKLIST: REVIEW OF SYSTEMS

GENERAL
- ☐ Weight loss or gain
- ☐ Fatigue
- ☐ Fever or chills
- ☐ Weakness
- ☐ Trouble sleeping

SKIN
- ☐ Rashes
- ☐ Lumps
- ☐ Itching
- ☐ Dryness
- ☐ Color changes
- ☐ Hair and nail changes

HEAD
- ☐ Headache
- ☐ Head injury
- ☐ Neck Pain

EARS
- ☐ Decreased hearing
- ☐ Ringing in ears
- ☐ Earache
- ☐ Drainage

EYES
- ☐ Vision Loss/Changes
- ☐ Glasses or contacts
- ☐ Pain
- ☐ Redness
- ☐ Blurry or double vision
- ☐ Flashing lights
- ☐ Specks
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Last eye exam

NOSE
- ☐ Stuffiness
- ☐ Discharge
- ☐ Itching
- ☐ Hay fever
- ☐ Nosebleeds
- ☐ Sinus pain

THROAT
- ☐ Bleeding
- ☐ Dentures
- ☐ Sore tongue
- ☐ Dry mouth
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Thrush
- ☐ Non-healing sores

NECK
- ☐ Lumps
- ☐ Swollen glands
- ☐ Pain
- ☐ Stiffness

BREASTS
- ☐ Lumps
- ☐ Pain
- ☐ Discharge
- ☐ Self-exams
- ☐ Breast-feeding

RESPIRATORY
- ☐ Cough
- ☐ Sputum
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Painful breathing

CARDIOVASCULAR
- ☐ Chest pain or discomfort
- ☐ Tightness
- ☐ Palpitations
- ☐ Shortness of breath with activity
- ☐ Difficulty breathing lying down
- ☐ Swelling
- ☐ Sudden awakening from sleep with shortness of breath

GASTROINTESTINAL
- ☐ Swallowing difficulties
- ☐ Heartburn
- ☐ Change in appetite
- ☐ Nausea
- ☐ Change in bowel habits
- ☐ Rectal bleeding
- ☐ Constipation
- ☐ Diarrhea
- ☐ Yellow eyes or skin

URINARY
- ☐ Frequency
- ☐ Urgency
- ☐ Burning or pain
- ☐ Blood in urine
- ☐ Incontinence
- ☐ Change in urinary strength

VASCULAR
- ☐ Calf pain with walking
- ☐ Leg cramping

MUSCULOSKELETAL
- ☐ Muscle or joint pain
- ☐ Stiffness
- ☐ Back pain
- ☐ Redness of joints
- ☐ Swelling of joints
- ☐ Trauma

NEUROLOGIC
- ☐ Dizziness
- ☐ Fainting
- ☐ Seizures
- ☐ Weakness
- ☐ Numbness
- ☐ Tingling
- ☐ Tremor

HEMATOLOGIC
- ☐ Ease of bruising
- ☐ Ease of bleeding

ENDOCRINE
- ☐ Head or cold intolerance
- ☐ Sweating
- ☐ Frequent urination
- ☐ Thirst
- ☐ Change in appetite

PSYCHIATRIC
- ☐ Nervousness
- ☐ Stress
- ☐ Depression
- ☐ Memory loss