ESTABLISHED
PATIENT REGISTRATION
(Please Print Clearly)

Today's Date: _____

COVINA
URGENT CARE
605 E Badillo St, Covina, CA 91723

IT IS VERY IMPORTANT THAT WE MAINTAIN ALL OF YOUR INFORMATION UP TO DATE

Since your last visit (or in the last 6 months) have there been any changes to your:

NAME ☐ INSURANCE ☐ ADDRESS ☐ PHONE ☐

Fill in all your current information:

Last Name	First Name	Age	Date of Birth

Address:

Mobile Phone:	Home / Secondary Phone:

EMAIL:

Sex M ☐ F ☐	Primary Care Physician

Patient's Signature: _____(SIGN HERE)

If the patient is a minor, then Parent / Guardian signs

1)	Do you have secondary health insurance?	YES	☐	NO	☐
2)	Are any of your injuries related to a car accident?	YES	☐	NO	☐
3)	Are any of your injuries sustained from a work-related injury?	YES	☐	NO	☐
4)	Do you agree to pay if your insurance does not pay?	**YES**	☐		
5)	You must inform staff if you are vomiting so we can provide you with assistance and vomit bags. You understand you will be charged $200 for leaving vomit or other body fluids / waste for others to clean up.	**YES**	☐		

Allergies and **Medical Conditions** We Need to Be Aware Of:

_____

_____

List of Medications (we do not refill controlled meds, but as a courtesy we can refill non-controlled meds):

_____

_____

_____

Preferred Pharmacy:

_____

Explain the **Reason** for Your Visit Today:

_____

_____

Covina Urgent Care Record

605 E Badillo Street, Suite 110 Covina, CA 91723 (626)732-9232

Please Fill in Highlighted Areas In **BLACK INK** Only

Last Name	First Name	Age	Date of Birth	Today's Date

Sex M ☐ F ☐	Primary Care Physician	PCP Location (City, State):

Responsible Party (print): _____

Authorization: I consent to any medical or surgical treatment, or services rendered under the instructions of the physician. I also accept responsibility for all charges related to this treatment and authorize any insurance payments directly to Covina Urgent Care. Authority is granted, in accordance with HIPAA standards, to furnish requested public health information to the patient's health insurer or healthcare provider for the purpose of treatment, payment, and/or health care operations

Signature: _____ **Relation**: _____ **Date & Time**: _____

Please do NOT fill out below

Temp (F)	Pulse (bpm)	SpO2 (%)	Respiration (rpm)	Blood Pressure	Weight (lbs.)	Height	LMP	FBS (mg/dL)	MA Signature:
				/			/ /		☐ Name, DOB ☐ PCP ☐ Vitals CC

ALLERGIES: ☐ NKDA ☐ UKN ☐ PCN ☐ Sulfa

CHIEF COMPLAINT:

Problems	Days	Problems	Days	Orders	Results	Current Medications
☐ Fever		☐ Diarrhea		☐Strep		
☐ Cold		☐ Abdominal Pain		☐UA		
☐ Cough		☐ Rash		☐HCG		
☐ Sore Throat		☐ Headache		☐IPPB		
☐ Loss of Appetite		☐ Laceration		☐E.LAV		
☐ Earache				☐HHN		
☐ Vomiting				☐X-RAY		

S _____

_____

_____

O

Physical Examination	N	AB
General Appearance		
Skin		
HEENT / Neck		
Chest / Lungs		
Heart		
Abdomen		
Neuro		
Back & Extremities		

_____

_____

_____

_____

A _____

_____

_____

P _____

_____

INJSITE _____ **LOT#**_____ **INJ**_____ **ORAL**____ **MA**____

Provider Signature & Date _____

Provider Stamp: