XCEL URGENT CARE

PATIENT INTAKE FORM – IMMIGRATION EXAM

Date: _____ Time: _____

First Name: _____ Middle Name: _____

Last Name: _____ Do you have Health Insurance? ☐ Yes ☐ No

Date of Birth: Month: _____ Day: _____ Year: _____ Age: ____ Sex: □ M □ F □ Other

Street Address: _____

Apt/Unit/Suite: _____ City: _____ State: _____ Zip Code: _____

Country of Birth: _____ City of Birth: _____

Phone Number: _ _ _-_ _ _-_ _ _ _ Email: _____ USCIS number A- _____

List medical problems: _____

List surgeries you had: _____

List medicines you take: _____

Have you had chickenpox (varicella)? ☐ Yes ☐ No

Allergies: _____ **USCIS Interview Date:** ____/____/20____

How did you hear about Xcel Urgent Care?

☐ **Google/Search** ☐ **Insurance website** ☐ **Referral** ☐ **Advertisement** ☐ **Walking by** ☐ **Other:** _____

DO NOT WRITE BELOW THIS LINE

Vitals:	BP: ___ /___	HR:_____	Resp: _____	Temp: ___.__ F	Height _____	Weight ____

Tests: ☐ QF ☐ RPR (**18-44 yrs**) ☐ GC (**18-24 yrs**) ☐ MMR ($35) ☐ Varicella ($15) ☐ Hep B Antibody ($15)

Vaccines: ☐ Tdap ☐ MMR ☐ Varivax ☐ Flu ☐ Covid-19 ☐ Hep B ☐ Other_____

Payment amount: _____ Method: ☐ Credit Card ☐ Cash ☐ Check

Room Number: _____

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