Avalon Urgent Care

805 Hill Blvd, Ste 102, Granbury, Texas 76048
Phone (817)579-7557 Fax (817)579-6166

Patient Information

Name: First		Middle		Last	
Male / Female	SS#		Marital Status	Age	Birthdate
Address			City	State	Zip Code
Home Phone		Cell Phone		Work Phone	
Patient Employer			Patient Occupation		
Address		City		State	Zip Code

Responsible Party *(if other than patient)*

Name: First		Middle			Last	
Date of Birth	Age	Male / Female	SS#			Marital Status
Home Phone		Cell Phone			Work Phone	
Address				City	State	Zip Code
Relationship to Patient						
Employer				Occupation		
Address		City			State	Zip Code

Additional Information

Primary Care Physician	May we send office notes to your PCP?	
Is this visit the result of a work related injury?	Date Injured	Claim #
Is this visit the result of a car accident?	Accident Date	Attorney Name

What pharmacy do you prefer?	Who can we thank for referring you to us?

Release Form For Individuals Involved in Patient Care

I, ____ give Avalon Urgent Care, in association with the licensed providers and contracted personnel, permission to speak to the following people regarding my health status, including diagnosis, treatment options, plans and payment for health services I receive. I further understand that I am responsible for providing written revocation should this information change.

Name: ____ **Relationship:** ____

Name: ____ **Relationship:** ____

Name: ____ **Relationship:** ____

Past Medical History	***Type***	***Year***	***Family History?***		***Type***	***Year***	***Family History?***
Arthritis □ Osteo / □ Rheumatoid				High Cholesterol			
Blood Disorders				Kidney Problems			
Cancer				Liver Problems, Hepatitis			
Diabetes □ type 1 or □ type 2				Lung Problem			
Ear/Nose/Throat				Joint/Back Problems			
Gastrointestinal				Neurology: Stroke/Seizures			
Genitourinary/Prostate				Psychiatric			
Heart Problems				Sexually Transmitted Diseases			
High Blood Pressure				Thyroid □ hypo / □ hyper			
Other:							

Surgeries	***Type***	***Year***		***Type***	***Year***
Head/Neck/Breast:			Heart/Lung:		
Abdominal/Pelvic:			Spine:		
Bone/Joint:			Other :		

Social History
Cigarettes: □ Never a Smoker □ Current Every Day Smoker □ Former Smoker (Year quit ___________) Packs Per Day: □ ½ □ 1 □ 1 ½ □ 2 □ 2 ½ □ 3 or more Other: □ Cigars □ Chew or Snuff □ Exposure to smoke in household.
Alcohol Use: □ None □ Rare □ Social (1-2 drinks per week) □ Regularly (3+ Drinks week) □ Daily □ Current Alcoholic □ History of Alcoholism □ Exposure to alcoholic in the household □ Quit
Street/Unprescribed Drug Use: □ Never Drug: □ Heroin □ Meth □ Prescription drugs:__________ □ Marijuana □ Cocaine □K2 □Bath salts Frequency: □ Rarely □ Occasionally □ Frequently □ Daily or almost daily □ In past, not currently

Privacy Practices Acknowledgment

I have received the Notice of Health Information Privacy Practices and I have been provided an opportunity to review it.

Patient Name ____ Birthdate ______________________

Signature ____ Today's Date ______________________

____________________________***Patients: Please do not write below this line.***____________________________

To be completed by office staff only.

____ Patient refused to sign.

____ Patient representative not available to sign.

____ Language, communication, or effects of disability
. impeded acknowledgment.

____ Emergency care impeded acknowledgment.

____ Other, please specify.

Staff Member Signature:

____

Date_____________________________

Avalon URGENT CARE#
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www.avalonurgentcare.com

Name: ________________________________ DOB________________ Date________________

Phone: _______________________________

Any Allergies to Medications: **Y** **N** If Yes, list: ____

Prescription Insurance: **Y** **N**

Current Medications: *(if you have a list, we can make a copy)* ______________________________________

____

____

Reason for visit:____

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Last Menstrual Period_____________________________

Which PHARMACY do you prefer?

(Please circle all that apply for TODAY'S VISIT ONLY)

GENERAL: □ chills, □ fatigue, □ fever, □ weight change

EYES: □ blurred vision, □ eye pain, □ sensitivity to light

E/N/T: □ hearing problems, □ ear/nose/throat pain, □ congestion, □ runny nose, □ bleeding nose, □ hoarseness, □ dental pain

CARDIOVASCULAR: □ chest pain, □ palpitations, □ fast heartbeat, □ difficulty breathing, □ swelling of legs

RESPIRATORY: □ cough, □ shortness of breath, □ wheezing

GASTROINTESTINAL: □ abdominal pain, □ heartburn, □ constipation, □ diarrhea, □ stool changes, □ nausea, □ vomiting

GENITOURINARY: □painful urination, □ genital lesions, □ blood in urine, □ impotence, □ freq urination, □ urine stream changes.

MUSCULOSKELETAL: □ joint pain, □ back pain, □ muscle pains

INTEGUMENTARY: □ suspicious moles, □ dry skin, □ itching, □ rashes

NEUROLOGICAL: □ dizziness, □ headaches, □ changes in sensation – numbness or tingling, □ weakness

HEMATOLOGIC/LYMPHATIC: □ easy bruising, □ bleeding, □ swollen lymph nodes

ENDOCRINE: □ hair loss, □ heat/cold intolerance, □ extreme thirst, □ extreme hunger

ALLERGIC/IMMUNOLOGIC: □ allergies, □ frequent illnesses, □ HIV exposure, □ hives

PSYCHIATRIC: □ anxiety, □ depression, □ sleep disturbances

Office Use Only

Wt__________ Ht_____________ Temp___________ BP_____________Pulse__________SpO2__________ Resp______

Lab:

Rpd Strep	Rpd Flu	bHcg	Mono	Rpd Adeno	RSV	Rpd Trich	Glucose			Room #	
+ / -	+ / -	+ / -	+ / -	+ / -	+ / -	+ / -					
Urinalysis	Blood	Urobili	Bilirubin	Protein	Nitrite	Ketones	Asc Acid	Glucose	pH	S/Gravity	Leuk.

Additional Notes:

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