PATIENT INTAKE FORM, SHEET 1

FULL LEGAL NAME:		DATE:	
GENDER:		DATE OF BIRTH:	
ADDRESS:			
EMAIL:			
PHONE:			
MAY WE LEAVE MESSAGES AT THIS NUMBER?	Yes ☐ No ☐		
EMERGENCY CONTACT NAME:			
EMERGENCY CONTACT RELATIONSHIP:			
EMERGENCY CONTACT PHONE:			

Bee Well
Urgent Care

PERSONAL MEDICAL HISTORY

ALLERGIES:			
PAST MEDICAL HISTORY:			
MEDICATIONS:			
PAST SURGERIES:			
FAMILY HISTORY (PARENTS, GRANDPARENTS, SIBLINGS, CHILDREN):			
DO YOU SMOKE?	Yes ☐ No ☐	IF SO, HOW MUCH?	
HAVE YOU EVER SMOKED?	Yes ☐ No ☐	IF SO, HOW MUCH?	
DO YOU DRINK?	Yes ☐ No ☐	IF SO, HOW MUCH?	
PRIMARY MEDICAL DOCTOR/PROVIDER:			
SPECIALTY DOCTORS CURRENTLY SEEING:			

PATIENT INTAKE FORM, SHEET 2

DATE:		DATE OF BIRTH:	
NAME:		**Bee Well Urgent Care** 	
Social Security Number:			
Relationship Status (Single/Married/Divorced/Widowed)			
Pharmacy of Choice			

PERSONAL MEDICAL INFORMATION

IS THERE ANYONE YOU WOULD LIKE TO HAVE ACCESS TO YOUR PERSONAL MEDICAL INFORMATION?	Yes ☐ No ☐	
	HIPAA LAW PROHIBIT THE SHARING OF YOUR PERSONAL MEDICAL INFOMRATION UNLESS YOU ASK US TO RELEASE IT. YOU MAY REVOKE THIS PERMISSION AT ANY TIME BY SUBMITTING A WRITTEN REQUEST.	
NAME/RELATIONSHIP:		
PHONE:		
NAME/RELATIONSHIP:		
PHONE:		
NAME/RELATIONSHIP:		
PHONE:		

PERSONAL PREFERENCES

HOW DO YOU PREFER TO PAY?	Venmo ☐ Bank Debit ☐ Cash ☐	Credit Card ☐ Check ☐
HOW DO YOU PREFER TO BE BILLED?	Mail ☐ Text ☐	Email ☐
HOW DO YOU PREFER TO MAKE APPOINTMENTS?	Online ☐ Call ☐	Email ☐
HOW DID YOU LEARN ABOUT US?	Facebook ☐ Advertisement ☐	Referral ☐ Other: