GLOBAL URGENT CARE OF VICTORVILLE SIGN-IN SHEET Account#:_____

REASON FOR VISIT_____ TODAY'S DATE_____ TIME_____

PATIENT'S FIRST NAME_____MIDDLE_____LAST_____

DATE OF BIRTH_____SS# _____ SEX: (F) OR (M) RACE_____ETHNICITY_____

HOME/CELL PHONE_____WORK PHONE_____ MARITAL STATUS: S M D SEP W

STREET ADDRESS_____CITY_____STATE_____ZIP_____

DATE OF LAST MENSTRAL_____ IF PREGNANT, EXPECTED DUE DATE_____

EMPLOYER_____OCCUPATION_____

EMPLOYERS ADDRESS_____CITY_____STATE____ZIP_____

PRIMARY PHSICIAN'S NAME_____ Do you have an Advance Directive? [ ]Yes [ ]No

Do you give permission to share immunization history? [ ] Yes [ ] NO - OPT OUT Do you give permission for our facilities to send you info that might prove helpful from a Healthcare standpoint? [ ] YES [ ] NO - OPT OUT CCD PREFFERED LANGUAGE_____ **Smoking Status**: Never Current Light Heavy Daily Unknown Email address_____ to receive invite on how to explore your personal healthcare information through our "Patient Portal". Please refer to handout for more details.

GUARANTOR/RESPONSIBLE PARTY INFORMATION:

NAME_____SS#_____DOB_____

MAILING ADDRESS_____CITY_____STATE_____ZIP_____

RELATIONSHIP _____HOME/CELL PHONE_____WORK PHONE_____

EMPLOYER_____OCCUPATION_____

EMPLOYERS ADDRESS_____CITY_____STATE_____ZIP_____

NEXT OF KIN/EMERGENCY CONTACT:

NAME: _____RELATIONSHIP_____PHONE_____

ADDRESS_____CITY_____STATE_____ ZIP_____

NAME: _____RELATIONSHIP_____PHONE_____

*******DO NOT COMPLETE THE FOLLOWING**********

PRIMARY INSURANCE NAME (HMO)_____POLICY ID#_____

SECONDARY INSURANCE NAME (HMO)_____POLICY ID#_____