

Date: \_\_\_\_\_

**Scioto Urgent Care  
6350 Frantz Rd. Suite H  
Dublin, OH 43017**

***General***

Patient Name: \_\_\_\_\_  
( LAST) ( FIRST) ( MI)  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Gender: M F  
SS#: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Martial Status: M S D W  
Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_  
Employer Name: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_  
Primary Care Physician Name: \_\_\_\_\_ Dr. Phone: \_\_\_\_\_  
How did you hear about us? \_\_\_\_\_

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***Emergency Contact information***

Emergency Contact Person

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

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***Guarantor Information( if other than patient)***

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
Street City State Zip  
Relationship to patient: \_\_\_\_\_ SSN: \_\_\_\_\_ Birth Date: \_\_\_\_\_

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***Insurance Information (Must be completed)***

Primary Insurance: \_\_\_\_\_ Policy Holder's Name: \_\_\_\_\_  
Relation to Policy Holder: \_\_\_\_\_ Policy Holder's DOB: \_\_\_\_\_ CoPay amt: \_\_\_\_\_  
Policy Holder's SSN: \_\_\_\_\_ I/D Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

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List all medications you are currently taking: \_\_\_\_\_

List any herbal vitamins, nutritional supplement or minerals you take: \_\_\_\_\_

List any allergies to medications you have: \_\_\_\_\_

List any medical conditions you have: \_\_\_\_\_

List any family medical conditions: \_\_\_\_\_

Do you use any alternative medicine, like chiropractics / acupuncture, etc: \_\_\_\_\_