



Gold Canyon
Urgent Care & Family Medicine
High Tech Care, Small Town Feel

Patient Registration Form

Last Name: _____ First Name: _____ MI: _____

Birth date: _____ SSN: _____ Gender (please X): Male Female

Primary Address: _____ City: _____

State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Secondary Address: _____ City: _____

State: _____ Zip: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Reason for today's visit: _____

Primary Pharmacy: _____ Location: _____

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MINORS ONLY

Mother:

Last Name: _____ First Name: _____ MI: _____

Birth date: _____ SSN: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Father:

Last Name: _____ First Name: _____ MI: _____

Birth date: _____ SSN: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Name: _____ Policy Number: _____

Employer: _____ Address: _____ City: _____

Zip: _____ Phone Number: _____

(If policy holder is NOT patient)

Policy Holder: _____ Relationship to Patient: _____

Birth date: _____ SSN: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____



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Patient Medical History

Patient Name: _____ Gender: Female Male Date of Birth: _____

Primary Care Physician: _____

Medicine

Allergies: _____

Current

Medications: _____

Past Medical

History: _____

Reason for

visit: _____

Please check positive family medical history below:

Mother: Deceased Diabetes Asthma Cancer Hypertension Coronary Artery Disease
Father: Deceased Diabetes Asthma Cancer Hypertension Coronary Artery Disease
Sibling: Deceased Diabetes Asthma Cancer Hypertension Coronary Artery Disease

Please check positive social history below:

Smoker: No Yes _____ pack/day for _____ years Quit _____
Alcohol: Never Rarely Occasional Heavy Quit _____
Recreational Drugs: No Yes Quit _____
Recently Traveled Abroad: No Yes, Location: _____
Lives Locally: No Yes, if No

where: _____

Surgical History: appendectomy gall bladder removal hysterectomy

other _____

Additional

Notes: _____

Patient Signature: _____

Physician

Signature: _____