UMD CARE
UNITED MEDICAL DOCTORS

"Your Health, Our Priority"

www.umdcare.com

PATIENT INFORMATION

Please present your insurance card and a photo ID at time of check-in

Patient's Name : Last First Gender : M / F

Social Security Number : Date of Birth : (mm/dd/yy)

Address : Street Address APT City State Zip Code

Mobile# Home# Work#

Email Address Occupation :

Race : Ethnicity : Preferred Language :

Pharmacy Name : Phone :

Address : Street Address APT City State Zip Code

Primary Care Doctor Name : Phone :

Address : Street Address APT City State Zip Code

Please list any medical problems :

Please list any medications you are allergic to :

Please list any medications you are taking :

Please list any surgeries :

Please list any family history of diseases or conditions :

Smoking Status : ☐ Current Smoker ☐ Former Smoker ☐ Never Smoked

IF YOU DO NOT HAVE YOUR INSURANCE CARD :

PRIMARY INSURANCE ☐ Yes ☐ No

Company Name :

Relationship to Policy Holder :

☐ Self ☐ Spouse ☐ Child ☐ Domestic Partner

Policy Holder's Name :

Social Security Number :

Date of Birth : Gender : M / F

SECONDARY INSURANCE ☐ Yes ☐ No

Company Name :

Relationship to Policy Holder :

☐ Self ☐ Spouse ☐ Child ☐ Domestic Partner

Policy Holder's Name :

Social Security Number :

Date of Birth : Gender : M / F

REASON FOR VISIT

Please check one of the following :

☐ Employment related injury ☐ Motor Vehicle Accident ☐ A Physical ☐ Vaccinations ☐ Other

HOW DID YOU HEAR ABOUT US

☐ Google ☐ Yahoo ☐ Bing ☐ Subway Panel ☐ Online Banner ☐ Yelp ☐ Friend

☐ Other(Please Specify) :