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 : _____

Alternative contact : Name : _____ Phone : _____ Relationship : _____

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) : _____