



Covina Urgent Care
605 E. Badillo Street
Covina, CA 91723

URGENT CARE · ESTABLISHED PATIENT

REASON FOR VISIT RECORD

IT IS VERY IMPORTANT THAT WE MAINTAIN ALL OF YOUR INFORMATION UP TO DATE

Since your last visit (or in the last 6 months) have there been any changes to your:

NAME

INSURANCE

ADDRESS

PHONE

Fill in all your current information:

Last Name	First Name	Age	Date of Birth	Today's Date
Address:				
Mobile Phone:		Home / Secondary Phone:		
EMAIL:				
Sex M <input type="checkbox"/> F <input type="checkbox"/>	Primary Care Physician			

Patient's Signature: _____

If the patient is a minor, then Parent / Guardian signs

1. Do you have any other health insurance (secondary)? YES NO If yes _____
2. Is there any indication you may be pregnant? YES NO
3. Are any of your injuries related to a car accident? YES NO
4. Are any of your injuries sustained from a work-related injury? YES NO
5. Do you agree to pay if your insurance does not pay? YES

Explain the Reason for Your Visit Today:

Allergies and Medical Conditions We Need to Be Aware Of:

VERIFIED BY:

INPUTTED BY:

Covina Urgent Care Record

605 E Badillo Street, Suite 110 Covina, CA 91723 (626)732-9232

Please Fill in Highlighted Areas in **BLACK INK** Only

Last Name	First Name	Age	Date of Birth	Today's Date
Sex M <input type="checkbox"/> F <input type="checkbox"/>	Primary Care Physician	PCP Location (City,State):		
Responsible Party (print): _____				
Authorization: I consent to any medical or surgical treatment, or services rendered under the instructions of the physician. I also accept responsibility for all charges related to this treatment and authorize any insurance payments directly to Covina Urgent Care. Authority is granted, in accordance with HIPAA standards, to furnish requested public health information to the patient's health insurer or healthcare provider for the purpose of treatment, payment, and/or health care operations				
Signature: _____ Relation: _____ Date & time: _____				

***** Please do NOT fill out below *****

Temp (F)	Pulse (bpm)	SpO ₂ (%)	Respiration (rpm)	Blood Pressure /	Weight(lbs.)	Height ' "	LMP / /	FBS(mg/dL)	M.A. Signature:	Name/DOB PCP Vitals/CC
Allergies: _____										
Chief Complaint: _____										

Problems	Days	Problems	Days	Orders	Results	Current Medications
<input type="checkbox"/> Fever		<input type="checkbox"/> Diarrhea		<input type="checkbox"/> Strep		
<input type="checkbox"/> Cold		<input type="checkbox"/> Abdominal Pain		<input type="checkbox"/> UA		
<input type="checkbox"/> Cough		<input type="checkbox"/> Rash		<input type="checkbox"/> HCG		
<input type="checkbox"/> Sore Throat		<input type="checkbox"/> Headache		<input type="checkbox"/> IPPB		
<input type="checkbox"/> Loss of Appetite		<input type="checkbox"/> Laceration		<input type="checkbox"/> E.LAV		
<input type="checkbox"/> Earache				<input type="checkbox"/> HHN		
<input type="checkbox"/> Vomiting				<input type="checkbox"/> X-RAY		

S

O

Physical Examination	N	AB
General Appearance		
Skin		
HEENT / Neck		
Chest / Lungs		
Heart		
Abdomen		
Neuro		
Back & Extremities		

A

P

INJSITE _____ LOT# _____ INJ _____ ORAL _____ MA _____

Provider Signature & Date _____

Provider Stamp: