MOBILE Intake
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DO NOT FILL OUT **RED** SECTIONS

Patient: ____ DOB:__________
Street: ____
City: __________________State: _______ Zip: ___________ Phone: ______________
Race: [ ] American Indian/Alaskan [ ] Asian [ ] Black/African American [ ] Pacific Islander/Hawaiian [] White [] Decline
Ethnicity: [ ] Hispanic/Latino [] Not Hispanic/Latino [ ] Decline
Patient #: ________________
Appointment Date __________**TIME** ___________ **[] PCR [] Rapid Antigen [] Rapid Antibodies**
Charge: $______________ **[] Cash [] Credit**

Reason For Visit: **[] COVID symptoms [] COVID Exposure__________________________**
[] Travel [ ] Other______________________________________

History of Present Illness: [ ] No Symptoms [] Symptoms (circle all that apply) **Symptom Onset:** ____________

CONSTITUTIONAL	fever Tmax:	chills/Sweats	fatigue
NEUROLOGICAL	headache	light headedness	weakness
PSYCHIATRIC	anxiety/nerves	depression	
EYES	eye discharge	eye redness	eye pain
ENT	loss taste/smell	sore throat	nasal congestion
RESPIRATORY	cough	short of breath	wheezing
GASTROINTESTINAL	abdominal pain	diarrhea	nausea/vomiting
GU	dysuria/hematuria	flank pain	frequency/urgency
MUSCULAR	joint pain	muscle pain/aches	swelling

MEDICATIONS: [] NONE [] No Change____
ALLERGIES: [] No Allergies [] No Change ____
MEDICAL HISTORY: [] No Medical History [] No Change [ ] DM [ ] HTN [ ] Cholesterol [ ] CAD [ ] Asthma [ ] COPD [ ] Thyroid
Medical Problems/Major Surgeries: ____

SOCIAL HISTORY: []No Change **Tobacco:** []Never []Quit []Current **Alcohol:** []None []Quit []Rare []Occasional []Daily
Recent Travel: [] No [] Yes: Where? ______________________ When?__________________________

VACCINES: [] UTD [] Not UTD [] No vaccinations [] COVID 1 or 2 shot(s) Brand: _________Date:________ [] Flu shot: Year: ______

Consent to Treat: I authorize payment of benefits to Surfside Urgent Care for any services furnished. I understand that I am responsible for any amount not covered by insurance. I authorize Surfside Urgent Care to release information concerning health care, advice, treatment or supplies provided to me for the purposes of billing my insurance company and any medical professional involved in my present or future care. I give Surfside Urgent Care authorization to perform the treatments and/or procedures considered necessary for my wellbeing. I understand that such treatments and/or procedures will be clearly explained to me in advance. I fully understand that it is impossible to make any guarantees regarding the outcome of any medical treatment or procedure.

HIPAA: I give my permission to release or discuss information related to my medical care and treatment, including but not limited to diagnosis, test results, plan of care and billing details to:

1. Name: ______________________________ Relationship: __________ Phone: ____________________
2. Name: ______________________________ Relationship: __________Phone: ____________________
3. Special Instructions pertaining to HIPAA:____

Signature of Patient/Guardian: _______________________________________ **Date:** ____________