



**INTAKE FORM**

**PLEASE PRESENT YOUR INSURANCE CARD AT THE TIME OF CHECK-IN.  
PAYMENT IS EXPECTED AT THE TIME OF SERVICE. FILL OUT ALL THAT APPLY**

**Section A**

Patient Name \_\_\_\_\_ Sex \_\_\_\_\_ DOB or History# \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_ Work # \_\_\_\_\_

How did you arrive to our office?       walk-in       wheelchair       carried in by: \_\_\_\_\_

**All minors must complete.**

Parent or Guarantor's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

If you are a NEW PATIENT or HAVE NOT BEEN SEEN at Duke Urgent Care within the past 6 months, PLEASE FILL OUT. If you HAVE BEEN SEEN within the past 6 months at Duke Urgent Care, skip to SECTION B.

Address \_\_\_\_\_ City, State, Zip code \_\_\_\_\_

Place of Employment \_\_\_\_\_ Work Phone # \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone Number \_\_\_\_\_

Email Address \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Primary Care Phone # \_\_\_\_\_ Primary Care Fax# \_\_\_\_\_

Primary Care Address \_\_\_\_\_

**Section B**

**Please state the reason for your visit** \_\_\_\_\_

**Are you experiencing any of the following? Please check (√) all that applies.**

- Severe** chest pain       Difficulty breathing, wheezing, shortness of breath       Allergic reaction  
 Uncontrolled bleeding       **Severe** headache       Slurred speech       Loss of coordination or balance  
 Confusion/Disorientation       Dizziness       **Severe** numbness/weakness       Pregnancy bleeding/complications  
 Loss of consciousness       **Severe** abdominal pain       Age greater than 80 or less than 3 months

**Section C**

**IF THIS IS AN ON THE JOB INJURY PLEASE COMPLETE THE FOLLOWING**

Employer Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Employer Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Contact Person or Supervisor \_\_\_\_\_

**FOR OFFICE USE ONLY**

Consent signed       Refused

Arrival time: \_\_\_\_\_