ProHealth Urgent Care

In affiliation with Baptist Health International

"Together, We Are ProHealth."

6040 Castle Coakley, Christiansted VI 00820

PATIENT INFORMATION

Please print your answers.

Physician's Name:

ALLERGIES: If yes, please list

Name:
First / Middle / Last

Date of Birth:
MM/DD/YYYY

Address:
Physical/Mailing

City/State/Zip Code

Social Security Number:
xxx–xx–xxxx

Phone Numbers:
Home/Work/Cell/Other

Email Address:

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed

Primary language spoken in the home:

Race: ☐ Asian ☐ Native ☐ Black or African American ☐ White ☐ American Indian/Alaskan ☐ Other ☐ Decline to specify

Ethnicity: ◯ Hispanic ◯ Non-Hispanic ◯ Prefer not to answer

Do you want to list a religious affiliation? (if yes, please state religion):

Employer Information:
Place of Employment/Occupation

Employer Address (City, State & Zip Code)

Emergency Contact:
Name/Relationship

Phone Number

Financial Responsible Party:
Name/Relationship

Address (If different from above):
Physical/Mailing

City/State/Zip Code

Name of Insurance Company:

Subscriber's Name:
If other than the patient
Name/Relationship

Member ID#:

Date of Birth:
MM/DD/YYYY

Group ID#:

Social Security Number:
xxx–xx–xxxx

Preferred Pharmacy:

Reason For Visit: