



Ascent Urgent Care & Walk-In Clinic

Immigration Physical

Today's Date: _____ Patient Gender: Male Female
Form completed by : Self Parent/Guardian Spouse Other

Patient Information

Patient : _____
Last Name First Name Middle Name

Date of birth: _____ Country of birth: _____ City of birth: _____

Address: _____
Number & Street City State Zip

Home Phone: _____ Cell Phone: _____

Marital Status: (Please circle one) Single Married Widow Divorced

Parent/Guardian: _____ Parent/Guardian Date of birth: _____

Email address: _____ Passport # _____ A# _____

INS Physical Health Screening Questions

1. Do you have any Health Problems Yes No
2. Are you currently taking any medications Yes No
3. Have you ever had a Positive TB skin test Yes No
4. Have you ever been treated for TB Yes No
5. Have you ever had Chicken Pox in your life time Yes No
6. Any history of Drug abuse/Drug Addiction Yes No
7. Any history of Alcohol abuse/Alcohol Addiction Yes No
8. Any history of Mental Health Disorders Yes No
9. Any history of Sexually Transmitted Disease (STD) Yes No

Signature: _____ Date of Signature: _____

C A R E W I T H C O M P A S S I O N !

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