

**PATIENT INFORMATION**

(Type, then print or print and fill in.)

Patient Name:	Date of Birth:	Social Security Number:	
		Sex: M F	Marital status: S M D W

Address: [Address/ P.O Box, City, ST ZIP Code]

Home phone number:	Cell phone number:
Employer:	Employer phone number:

**PRIMARY INSURANCE INFORMATION**

(Please give your insurance card to the receptionist)

Policy Holder/Guarantor's name:	Relationship to patient:	Birth date:	Social Security number:
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Address: [Address/ P.O Box, City, ST ZIP Code]

Home phone number:	Cell phone number:
Employer:	Employer phone number:

**SECONDARY INSURANCE INFORMATION**

Policy Holder/Guarantor's name:	Relationship to patient:	Birth date:	Social Security number:
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Address: [Address/ P.O Box, City, ST ZIP Code]

Home phone number:	Cell phone number:
Employer:	Employer phone number:

### MEDICAL HISTORY

Drug Allergies:	Adequate Nutrition: Y   N	Sudden Weight Loss: Y   N	Sudden Weight Gain: Y   N
Fall Risk: Have you fallen in the past 6 months? Y   N	Abuse Screen: Are you being abused by anyone? Y   N	Suicide Risk Screen: Any thoughts of harming yourself? Y   N	

Please check if you have any of the following:

<input type="checkbox"/> Heart Disease/Heart Attack <input type="checkbox"/> Stroke <input type="checkbox"/> Diabetes <input type="checkbox"/> Lung Problems <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Stomach Ulcers/Disease <input type="checkbox"/> Bowel Problems <input type="checkbox"/> Hepatitis <input type="checkbox"/> Urinary Problems <input type="checkbox"/> Epilepsy/Seizures <input type="checkbox"/> Thyroid	<input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Hernia <input type="checkbox"/> HIV <input type="checkbox"/> Sexually Transmitted Infections/Disease <input type="checkbox"/> Pelvic Infections <input type="checkbox"/> Depression <input type="checkbox"/> Mental Illness <input type="checkbox"/> Lupus <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Previous Cancer—if so, what kind? _____
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Do you have a family history with any of these conditions? (state relationship please)  
 Mother: M   Father: F   Brother: B   Sister: S   Grandmother: GM   Grandfather: GF

<input type="checkbox"/> High Blood Pressure (Hypertension) <input type="checkbox"/> Lung Disease <input type="checkbox"/> Stroke	<input type="checkbox"/> Heart Disease/Heart Attack <input type="checkbox"/> Sexually Transmitted Infections/Disease <input type="checkbox"/> Previous Cancer—if so, what kind? _____
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Past Surgeries or Hospitalizations: \_\_\_\_\_ Date: \_\_\_\_\_

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Have you been involved in a motor vehicle accident that brought you to the clinic today? **PHYSICIANS URGENT CARE CLINICS DO NOT TREAT ANY MOTOR VEHICLE ACCIDENTS**      Y   N

Is your visit today related to a worker's comp injury?   Y   N    (if so, please notify front desk immediately)

Do you smoke? Y   N  If so, how much? _____	Do you drink more than 2 alcoholic beverages on a daily basis? Y   N	Do you use street drugs/narcotics? Y   N  If so, please explain: _____
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**PHARMACY/PRESCRIPTION INFORMATION**

PHARMACY:

PHARMACY PHONE NUMBER:

PRESENT MEDICATIONS/DOSAGE:

WHO PRESCRIBED IT?

**COMMUNICATION**

Physicians Urgent Care has the ability to provide patients with certain types of information via e-mail and/or text messaging. The types of information that can be communicated via e-mail/text with the patient include: appointment scheduling requests, billing and insurance questions, lab results, general questions, and patient education.

Physicians Urgent Care believes strongly in protecting the privacy of our patients. When you authorize Physicians Urgent Care to communicate with you via e-mail and/or text, it is only used as a way to communicate with you. Transmitting information via e-mail and/or text has a number of risks involved. By authorizing Physicians Urgent Care to e-mail and/or text, the patient is aware of the potential risks involved.

**Please check one:**

I authorize Physicians Urgent Care to use e-mail or text as a communication tool. I understand the risks involved in using e-mail and/or text messaging to communicate with Physicians Urgent Care. This authorization will remain in effect unless I terminate the arrangement in writing. I agree to indemnify and hold harmless Physicians Urgent Care as the results of any issues arising from e-mail or text communications.

If agreed, please provide email and phone number:

\_\_\_\_\_

\_\_\_\_\_

I DO NOT authorize Physicians Urgent Care to communicate via e-mail or text. This denial will remain in effect unless I updated my authorization in writing.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

## PHYSICIANS URGENT CARE

- STATE OF FINANCIAL RESPONSIBILITY: Unless otherwise prohibited, I unconditionally guarantee payment in full to Physicians Urgent Care.
  - I hereby authorize and consent to the release of all medical and personal information (including but not limited to my home phone, cell phone, work phone, address and email address) by or to Physicians Urgent Care and all healthcare professionals involved in my care, interpretation of test results, account billing and collections, payment posting and/or claim processing, or related healthcare functions. This authorization shall remain in effect until such time as all account balances extending from the encounter have been fully satisfied.
  - I authorize Physicians Urgent Care and all clinic providers who have provided care or interpreted my tests, along with any billing service, collection agency or attorney who may work on their behalf to contact me on my cell phone and/or home phone using pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology or by electronic mail, text messaging or by any other form of electronic communication.
  - ASSIGNMENT OF INSURANCE BENEFITS: As a patient, I hereby make the assignment of benefits as set forth below.
  - MEDICARE AND/OR MEDICAID: I request that payment of authorized Medicare/Medicaid benefits to or on my behalf for services furnished in or by Physicians Urgent Care shall be made to Physicians Urgent Care and I specifically assign such benefits to Physicians Urgent Care. I hereby certify that all information given by me in connection with applying for benefits under Title XVII of the Social Security Act is true, correct, and complete in all respects. I understand that payment for certain services not deemed medically necessary by Medicare/Medicaid are not authorized under Medicare/Medicaid Program and that I may be responsible for the entire charge incurred unless third party coverage is available. I also understand all deductibles are due unless they have been met within the period specified by Medicare.
  - INSURANCE: I hereby assign to Physicians Urgent Care all rights, benefits, and interest under any insurance policy, health plan, workers' compensation, or third-party payor liable to me, in consideration for services rendered by Physicians Urgent Care. I hereby authorize payment directly to Physicians Urgent Care by any insurance policy, health plan, or third-party payor for treatment received at Physicians Urgent Care. I hereby authorize payment directly to Physicians Urgent Care for workers' compensation coverage for medical expenses for medical treatment received at Physicians Urgent Care. I hereby authorize payment directly to Physicians Urgent Care of all third-party liability insurance coverage, third-party payor, health plan, and individual liability insurance for medical expenses incurred as a results illness for which I received treatment at Physicians Urgent Care.
  - To the extent allow by law, I remain responsible for any portion of the Physicians Urgent Care Urgent Care Clinic bill not paid by insurance, including co-insurance, denied claims or deductibles; I am responsible for any unpaid charges incurred.
  - I understand on occasion, I might be treated by a new provider who is going through the insurance credentialing process, to be included in an insurance network. I understand that I, possibly, could be out of network for the new provider at Physicians Urgent Care. If my claim files out of network, I will bring to the Physicians Urgent Care my explanation of benefits to be evaluated.
  - RELEASE OF INFORMATION: In addition to that provider above, Physicians Urgent Care may disclose all or part of my medical record when such disclosure is necessary for my continued treatment, the payment for the services I receive, for healthcare operation or as may be required or allowed by applicable law. I permit a copy of these authorizations and assignment to be used in place of the original.
  - I authorize the provider assigned to furnish medical and surgical treatment by those means he/she considers necessary and proper in my treatment, identified below while I am a patient of Physicians Urgent Care Clinics. This treatment may require diagnostics procedures including but not limited to laboratory tests, blood drawing for those tests, x-rays and electrocardiogram.
  - NOTICE OF PRIVACY PRACTICES: (check one of the boxes)
    - Acknowledgement: I acknowledge that I have been offered, given, and received a copy of the Physicians Urgent Care LLC Notice of Privacy Practices. (My acknowledgement does not mean I agree with the Notice of Privacy Practices or that I have read the Notice of Privacy Practices, it only means I acknowledge receipt of a copy).
    - Acknowledgement if patient is a minor or otherwise incompetent to sign: I hereby acknowledge that I have been given and received a copy of Physicians Urgent Care LLC Notice of Privacy Practices on behalf of the patient. (My acknowledgement does not mean I agree with the Notice of Privacy Practices or that I have read the Notice of Privacy Practices, it only means I acknowledge receipt of a copy).
- THIS IS TO CERTIFY THAT I, THE UNDERSIGNED, BEING THE PATIENT OF ANOTHER PERSON LEGALLY AUTHORIZED TO ACT FOR THE PATIENT, HAVE READ THE ABOVE PARAGRAPHS.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

**IN CASE OF EMERGENCY**

Physicians Urgent Care will not discuss your personal health information or billing with anyone except those allowed under Federal and State law without your consent. Please list the name and relationship of those you authorize to discuss your personal health information with. We will use these authorized persons as your emergency contact, as well.

Name:	Relationship to patient:	Phone number:
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Name:	Relationship to patient:	Phone number:
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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I, also, authorize Physicians Urgent Care or insurance company to release any information required to process my claims.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date