URGENT CARE MD

New Patient Registration

Patient Information:

Name (First, Middle, Last):_____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone Number: (Home) _____ (Cell) _____

Date of Birth: _____ Gender: M/ F Social Security Number: _____ Marital Status:_____

Race: _____ Ethnicity: Hispanic / Non-Hispanic Preferred Language: _____

Email Address: _____ Preferred Contact Method: _____

Patient Employer Information:

Name of Company: _____ Phone Number: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Responsible Party/Guarantor (if different from above patient):

Name: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Relationship to Patient: _____

Emergency Contact Information:

Name: _____Relationship to Patient: _____Phone Number: _____

How did you hear about us? (Check one)

__ Relative __ Friend __ Radio __ Website __ Facebook __ Insurance __ Referring Physician

__ Drive By __ Patient __ Work __ Twitter __ Google __ YELP __ Neighborhood

I certify that the information provided above is complete and accurate to the best of my knowledge.

Patient/Guardian Signature: _____ *Date:* _____

For Front Desk Use Only:

Insurance Policy Holder Information:

Primary:

Insurance: _____ Member ID: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____

Policy Holder Sex: M/F Relationship to insured: ☐ Self ☐ Spouse ☐ Dependent

Secondary:

Insurance: _____ Member ID: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____

Policy Holder Sex: M/F Relationship to insured: ☐ Self ☐ Spouse ☐ Dependent

Patient Name:_____ DOB:_____ Date:_____

Chief Complaint/Why are you here? _____

Do you need a work/school note for your appointment today? _____

Which pharmacy & location would you like prescriptions (if any) sent to? _____

Current Medications:

_____

_____

Medication Allergies:

_____

_____

Please mark an (x) by any of these conditions you may have or have had in the past:

___Heart disease	___Liver disease	___High blood pressure	___ COPD
___High cholesterol	___Cancer (past or present)	___Thyroid	
___Diabetes	___Stroke	___Lung Disease	
___Kidney, bladder or prostate disease	___Asthma	___Other_____	

Females only:

Date of last menstrual cycle:_____

Could you be pregnant? Y/N Taking birth control? Y/N What medication? _____

Orthopedic or Other Major Surgeries:_____

Personal Habits

Do you drink alcoholic beverages? _____ If yes, _____ drinks/day week month

Do you smoke or chew tobacco? _____ If yes, _____/day, _____years of use

Family Medical History:

Mother:_____Brother/Siser: _____

Father:_____Other:_____

Are all Vaccines up to date? _____ YES _____No _____ Unknown

Clinic use only:

Check in_____ Room_____ Provider_____ID_____

MD Orders:

Vitals: _____

Temp_____ Respiration_____ _____

Pulse_____ O2 saturation_____ _____

BP _____ Height/Weight _____/_____ _____

MEDICAL RECORDS AND PATIENT INFORMATION CONFIDENTIALITY POLICY

Acknowledgement of Practice's *Notice of Privacy Practices*:

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

Printed Name of Patient: _____Date of Birth: _____

In compliance of state and federal regulations, Urgent Care MD will not release an individual's medical records or information without the patient's written authorization. The patient may restrict or revoke the authorization to release medical information at any time. We ask that you instruct us on what medical information can be shared, with whom, and by what means of communication.

- ❖ May Urgent Care MD send medical records to your primary care physician or other specialist physician at your request? □ Yes □ No
- ❖ May Urgent Care MD contact you by phone and if no answer leave a message for appointments, scheduling, referrals, prescriptions, labs, or other test results, etc.? □ Yes □ No
- ❖ Upon your request, may Urgent Care MD send you medical records via E-mail or fax? □ Yes □ No

If Urgent Care MD cannot reach you, is there another person with whom we can discuss your medical information? Please list relationship/contact phone numbers:

Name: _____Relationship:_____Phone#_____

Name: _____Relationship:_____Phone#_____

ALL PATIENTS: CASH PAY, MEDICARE, AND PRIVATE INSURANCES

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance. ***WE REQUEST THAT OUR CHARGE FOR OFFICE VISITS BE PAID AT THE TIME SERVICES ARE RENDERED.***

I authorize the release of any medical information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance and other agency reimbursements to Urgent Care MD. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature of Patient/Guardian: _____Date:_____