Convenient
URGENT CARE

CONFIDENTAL

PATIENT REGISTRATION

Date______________

Patient Name____ Date of Birth______________________

________________________________ | __________ | __________ | __________
Full Address | City | State | Zip Code

E-mail________________________________ Sex ☐M ☐F Age_____ Minor☐

Home Phone__________________________ Cell Phone____________________________

Marital Status: (Adults 18 and over)

☐ Married ☐ Widowed ☐ Single ☐ Separated ☐ Divorced

Race/Ethnic Group________________________________

Religion(optional)________________________________

Insurance Information:

Insurance Name______________________ Policy Holder Name _________________________

ID#__________________________ Date of Birth____________

☐ SELF-PAY (No Insurance)

Minor Information:

Guardian/Custodial Parent Name____

Guardian/Custodial Parent Address____

Home Phone____________________ Cell Phone_____________________ Work Phone____________________

***** IN CASE OF EMERGENCY, 18 & OVER*****

Name______________________________

Number______________________________

Relationship ______________________________

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MEDICAL HISTORY

Patient Name ______________________ Date of Birth ______________

Patient Concerns: ______________________

Date of Last Physical Exam________________

FAMILY MEDICAL HISTORY

	✓ If Alive	Age at Death	Present Health or Cause of Death		# Alive	# Deceased	Present Health or Cause of Death
Father				Brothers			
Mother				Sisters			
Spouse				Children			
			Age of Living Children:				

CHECK (✓) THE ILLNESS THAT HAVE OCCURRED IN YOUR IMMEDIATE FAMILY

☐ DIABETES ☐ CANCER ☐ BLEEDING TENDENCY ☐ KIDNEY DISEASE ☐ TUBERCULOSIS

☐ HEART DISEASE ☐ STROKE ☐ DEPRESSION ☐ HIGH BLOOD PRESSURE ☐ ALLERGIES

MEDICATIONS

LIST THE MEDICATIONS YOU ARE CURRENTLY TAKING VITAMINS/HERBS/SUPPLEMENTS, ETC.

____

____

____

____

ALLERGIES

CHECK (✓) IF YOU ARE ALLERGIC TO: ☐ **NONE**

☐ ADHESIVE/TAPE ☐ ASPIRIN

☐ IBUPROFEN ☐ IODINE

☐ LATEX ☐ LOCAL ANESTHESIA

☐ PENICILLIN ☐ SULFA

LIST ALLERGIES TO MEDICATIONS OR SUBSTANCES

____

____

PLEASE LIST ANY **CHRONIC CONDITIONS**

____

____

ACCIDENTS

____

____

PLEASE LIST ANY RECENT **DIAGNOSTIC TESTS**

____

____

PLEASE LIST ANY RECENT **INJURIES/ILLNESSES**

____

____

HOSPITALIZATIONS

____

____

SURGERIES

____

____

OTHER HEALTH CARE PROVIDERS

PRIMARY CARE PROVIDER ______________________

OB/GYN ______________________

OTHER ______________________

*****PREFERRED PHARMACY*****

Name ______________________

Cross Streets ______________________

Telephone ______________________

CERTIFICATION

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

____

****Signature of Patient/Guardian**** Date

____

****Please Print Name of Patient**** Date

General Consent for Treatment

The undersigned patient and/or responsible guardian hereby consent to and authorize **Convenient Urgent Care's** physicians and medical personnel to perform medical examinations, diagnostic procedures, medical or surgical treatments, and administer immunizations during the course of the patient's care as deemed advisable or necessary.

I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as the result of treatment or examination by the physicians and medical personnel of **Convenient Urgent Care.**

____ ____________________________

*****Print Patient Name ***** **Date of Birth**

____ ____________________________

*****Patient /Guardian Signature***** **Date**

ACKNOWLEDGEMENT / CONSENT RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have reviewed the Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this notice if requested.

Many of our patients allow family members such as their spouse, parents or others to receive medical information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

Patient Information: I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed. I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient. You have the right to revoke this consent in writing.

I authorize Convenient Urgent Care or Parker Family Practice to release my medical and/or billing information to the following individual(s):

1.____Relationship to Patient__________________

2.____Relationship to Patient__________________

3.____Relationship to Patient__________________

If you do not wish to release any medical and/or billing information please check box below.

☐ **I DO NOT wish to release my medical and/or billing information to any individual.**

____ ____________________________

*****Patient /Guardian Signature***** **Date**