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 _____

CONFIDENTAL

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**