Doctors' Choice Urgent Care

Patient Name: ____
First MI Last

Street Address: _______________________ Apt. #_______ City: _______________ State: ______ Zip: __________

DOB: _____/_____/_______ Social Security #: _____/____/______ Driver's License: _____/_______________
Month Day Year TX Number

Mobile Phone: (_____)_____-__________ Home Phone: (_____)_____-__________ Work Phone: (_____)_____-________

E-mail Address: ____

PLEASE LIST ANY AND ALL INSURANCE AND/ OR EMPLOYEE HEALTH CARE PLANS YOU OR YOUR SPOUSE MAY HAVE:

Primary Insurance Company: ________________________ Effective Date: _____/_____/____________

ID Number: _____________________________________ Group Number: _______________________

Name of Insured: ________________________________ DOB: ______/______/ __________________

Relationship to Insured: ____________________________ Social Security #: _____-____-_____________

Employer Name: __________________________________ Occupation: ___________________________

Address: ____ □ Full Time □ Part- Time OR □ Student

Marital Status of Patient: □ Single □Married □Divorced □Widowed

Emergency Contact: _______________________________ Relationship: _________________________

Mobile Phone: (_____) _____-__________ Home Phone: (_____) _____-__________ Work Phone:(_____)____-______

PREFERRED PHARMACY

Name: ____ Phone #: (_______) _______-___________

Address: ____

REASON FOR VISIT: ____

____

PAST MEDICAL HISTORY

□ **None apply**

Check ALL that apply:

□ Arthritis
□ Bleeding Disorders
□ Blood Clot
□ Lung Disease
□ Liver Disease
□ Heart Failure
□ Stroke
□ HIV
□ AIDS
□ Hepatitis
□ High Blood Pressure
□ Seizures
□ Thyroid
□ Diabetes
□ Mental Illness
□ Tuberculosis
□ Heart Attack
□ Kidney Stones
□ Asthma
□ Anemia
□ Kidney Failure
□ Gout
□ Cancer
□ Osteoporosis
□ Alcoholism
□ Ulcers
□ Smoke
□ Miscarriage/ Abortion
□ Other ___________________________

Are you pregnant? □ Yes □ No

When was your last menstrual cycle? _____/_____/________

MEDICATIONS

Please list ALL CURRENT medications and doses: □ **None**

____ ____
____ ____
____ ____

ALLERGIES

Please list all allergies, food or medication, and reactions: □ **I have no known drug/ medication allergies.**

____

I hereby give permission to Doctors' Choice Urgent Care to disclose and discuss any information related to my medical conditions to:

Name: ____ Relationship: ______________________________

Phone Number: (______) _____-________

Name: ____ Relationship: ______________________________

Phone Number: (______) _____-________

How did you hear about us?

□ Internet Search

□ Insurance

□ Physician

□ Walk- In

□ Other ___________________________

CONSENT FOR TREATMENT FORM

I understand that I have presented myself to the staff of Doctors' Choice Urgent Care for evaluation and/ or treatment for my condition. I authorize Doctors' Choice Urgent Care to perform quality care upon me, and understand that all options will be discussed prior to the administration of treatment. I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the outcome of any procedures and/ or treatments. I grant this consent without duress, confusion, or pressure from my physician and/ or his or her staff, associates, or colleagues. ______
Initials

FACSIMILE AUTHORIZATION FORM

I, the undersigned, authorize Doctors' Choice Urgent Care to send/ receive confidential healthcare information as the term is defined by HIPAA (Health Insurance Portability and Accountability Act of 1996, 45 C.F.R., Parts 160- 164) by facsimile to healthcare providers, hospitals, laboratories, and other medical caregivers in the necessary coordination of care for the patient listed below. I may revoke this authorization by giving Doctors' Choice Urgent Care a written notice. This revocation may be by facsimile transmission; however, a written copy of the revocation must be presented to Doctors' Choice Urgent Care. ______
Initials

ASSIGNMENT OF BENEFITS/ FINANCIAL AGREEMENT

I hereby give authorization for payment of insurance benefits to be made directly to Doctors' Choice Urgent Care and any assisting physicians, PA, NP, RNFA, OR CRNA for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original. ______
Initials

ACKNOWLEDGEMENT OF FINANCIAL INTERESTS

I, the undersigned, acknowledge that Doctors' Choice Urgent Care, at any given time, may be a consultant, manager, developer, or part owner of various entities that may have financial interests in various physician owned entities, medical device distributorships, management companies, and hospitals. ______
Initials

ACKNOWLEDGEMENT FORM

I have received and/ or reviewed the Notice of Privacy Practices. I have received a copy of the financial policy for this practice and agree to adhere to the terms. ______
Initials

THIS RELEASE WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING.

Patient Signature: ____ Date: ______/______/________

Witness Signature: _______________________________________ Date: ______/______/________