MyHealth Urgent Care

Patient Registration Form

PATIENT NAME: LAST_____ **FIRST**_____ **MI**_____

DATE OF BIRTH: _____ / _____ / _____ **SOCIAL SECURITY#:** _____/_____/_____ **SEX:** _____**M** _____**F**

CURRENT ADDRESS_____**APT#**_____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

HOME PHONE :(_____)_____ **CELL:** (_____)_____ **OTHER:** (_____)_____

WHICH PHONE NUMBER IS BEST TO CONTACT YOU AT? (PLEASE CIRCLE) HOME CELL OTHER

EMAIL ADDRESS: _____

RACE: _____ PREFFERED LANGUAGE: _____ ☐ HISPANIC

IS TODAYS VISIT RELATED TO: AUTO ACCIDENT YES ☐ **NO** ☐ **WORK RELATED INJURY: YES** ☐ **NO** ☐

HOW DID YOU HEAR ABOUT US? _____ **NAME (IF REFERRED):** _____

INSURANCE COVERAGE

PRIMARY POLICY:

POLICY HOLDERS NAME: _____ RELATIONSHIP TO PATIENT _____

POLICY HOLDERS D.O.B: _____/_____/_____ INSURANCE COMPANY_____

SECONDARY POLICY:

POLICY HOLDERS NAME: _____ RELATIONSHIP TO PATIENT _____

POLICY HOLDERS D.O.B: _____/_____/_____ INSURANCE COMPANY_____

PARENT/LEGAL GUARDIAN

(Our office policy is that the parent/legal guardian who BRINGS the child to the visit is the responsible party)

NAME: LAST_____ FIRST_____ MI_____

DATE OF BIRTH: _____/_____/_____ SOCIAL SECURTIY#_____/_____/_____ SEX: _____M _____F

RELATIONSHIP TO PATIENT: _____

☐ **Check box if address is the same as patient address**

CURRENT ADDRESS:_____

CITY: _____ STATE:_____ ZIP CODE:_____

HOME PHONE: (_____)_____ CELL: (_____)_____ OTHER: (_____) _____

RELEASE OF PROTECTED HEALTH INFORMATION

By signing this form, I authorize MyHealth Urgent Care, and its staff to use and disclose the protected health information described below, to the individuals named. These individuals may also pick up prescriptions, samples, medical records and other health related items on my behalf. **If patient is a minor, please list parents' names below.**

What level of information can we release

◯ All information including specific medication/dosages, Lab results and information related to sensitive issues such as sexually transmitted diseases (including but not limited to AIDS and Hepatitis C).

◯ No information whatsoever

To whom can we release information: (Please list names)

_____

_____

◯ No one except the patient can obtain information.

X_____

SIGNATURE OF PATIENT OR PARENT/ GUARDIAN IF MINOR

_____

DATE

NAME: _____ DATE: ____ /____ /_____

PAST MEDICAL HISTORY/ FAMILY HISTORY

	Yourself	Blood Relative (WHO?)		Yourself	Blood Relative (WHO?)
High blood pressure	☐	_____	High cholesterol	☐	_____
Diabetes	☐	_____	Heart Disease	☐	_____
Thyroid Disease	☐	_____	Cancer	☐	_____

Other: _____

MEDICATIONS (include over the counter): _____

_____

ALLERGIES: _____

SURGERIES: _____

MARITAL STATUS: _____ PREGANANT: Y / N OCCUPATION: _____

SMOKE? NO ___ Yes ___ packs/day ALCOHOL? No ___ Yes ___drinks/week DRUGS? NO___ YES: _____

****REQUIRED** PHARMACY NAME & CROSS STREETS:_____**

PRIMARY CARE DOCTOR & PHONE NUMBER**:**_____

***CHECK THE BOX NEXT TO THE SYMPTOMS YOU ARE EXPERIENCING FOR TODAY'S VISIT**

Constitution

☐	Chills
☐	Fatigue
☐	Fever
☐	Recent Weight Loss

Eyes

✔	Eye Itching
✔	Eye Matting/Discharge
☐	Eye Pain
☐	Eyelid Redness
☐	Vision Changes

Ent/Mouth

☐	Ear Drainage
☐	Ear Pain/Pressure
☐	Hearing Loss
☐	Hoarseness
☐	Popping of Ears
☐	Post-nasal Drip
☐	Sinus Pressure/Drainage
☐	Sore Throat
☐	Stuffy Nose
☐	Tinnitus (Ear Ringing)
☐	Toothache

Abdominal Issues

☐	Abdominal Pain
☐	Bloating
☐	Constipation
☐	Diarrhea
☐	Gas/Indigestion
☐	Nausea/Vomiting
☐	Rectal Bleeding
☐	Rectal Pain

GU

☐	Blood in Urine
☐	History of STD's
☐	Painful Urination
☐	Pregnancy
☐	Urinary Frequency
☐	Vaginal Discharge

Muscular/Skeletal

☐	Back Pain
☐	Joint Pain
☐	Muscle Aches
☐	Muscle Spasm
☐	Neck Pain
☐	Extremity Swelling

Blood

☐	Bleeding
☐	Easy Bruising
☐	Painful/Swollen Lymph node

Allergy/Immunization

☐	Allergies
☐	Hay Fever/Sneezing
☐	Hives
☐	Recurring Infections

Skin/Breast

☐	Bites/Sores
☐	Breast Lump
☐	Color Change
☐	Itch
☐	Lesion

Psych

☐	Anxiety
☐	Depression
☐	Insomnia

Neurology

☐	Dizziness
☐	Headache
☐	Loss Consciousness
☐	Muscle Weakness
☐	Numbness/Tingling
☐	Paralysis/paresis
☐	Poor Balance
☐	Speech Difficulties

Respiration

☐	Cough
☐	Coughing Blood
☐	Shortness of Breath
☐	Wheezing

Cardio

☐	Chest Pain
☐	Palpitations
☐	Shortness of Breath

☐ OTHER SYMPTOMS _____

MYHEALTH URGENT CARE, P.C.

GENERAL CONSENT TO TREATMENT FORM

(Please read carefully before signing)

1. Consent to Testing and Treatment

I voluntarily consent to urgent care which may include a complete medical history, physical examination, routine diagnostic procedures, and such medical treatment as is deemed necessary and appropriate by the physician, physician assistant and/or associates at MyHealth Urgent Care, P.C.

I understand and agree that in the very rare event that a health care provider at MyHealth Urgent Care, P.C. sustains a significant exposure to my blood and/or bodily fluids that MyHealth Urgent Care, P.C., may have laboratory studies performed on my blood to detect the presence of a potentially serious incubating communicable disease, such as hepatitis or AIDS. The result of any such test will be treated confidentially.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantee or promise has been made to me as to the results of the care and treatment which I have hereby authorized.

I authorize MyHealth Urgent Care, P.C. to dispose of any specimen or tissue remaining after completion of a clinical procedure or treatment.

2. Acknowledgment of Notice of Privacy Practices and Release of Medical Record Information

I acknowledge that I was offered and/or provided the MyHealth Urgent Care, P.C., Notice of Privacy Practices, and that I may obtain an additional copy of the Notice at any time. This Notice describes how MyHealth Urgent Care, P.C., uses and discloses medical information in accordance with the protections of the law.

I authorize MyHealth Urgent Care, P.C., to release pertinent information and/or copies of medical records of any information protected under the regulations in 42 Code of Federal Regulations, Part 2, if any, psychiatric/psychological/substance abuse/service records, if any, social work records, if any, including communications made to me by a social worker or psychiatrist/psychologist and any information about Human Immunodeficiency Syndrome (AIDS) to other institutions, physicians, third party payers, insurance companies or review agencies for use in connection with my care. I acknowledge that medical record information may be released to my employer if this is a work-related examination or injury for which a workers compensation claim has been filed.

3. Authorization for Payment

I assign and authorize payment directly to MyHealth Urgent Care, P.C., for any and all services rendered. I understand that I am financially responsible for services that may not be covered under my health insurance policy. I understand that it is my responsibility to pay, at the time of discharge, or on an interim basis as arranged with MyHealth Urgent Care, P.C., in accordance with its Payment for Services Policy (dated April 21, 2014) a copy of which I acknowledge that I have received, for all charges not covered by my insurance company, such as but not limited to deductibles and co-payments.

(Please read carefully before signing)

4. Additional Acknowledgements

I understand that MyHealth Urgent Care, P.C., and/or its business associates, may contact me by telephone at any telephone number provided by me or associated with my record, including cell phone numbers, which could result in telephone company charges to me. MyHealth Urgent Care, P.C., may also contact me by sending text messages or e-mail messages using the contact information I provide. Methods of contact may include using pre-recorded/synthetic voice messages and/or use of an automatic dialing device, if, when or as applicable.

I hereby release MyHealth Urgent Care, P.C., from responsibility for all personal articles which I have with me now and will have during my time as a patient at your urgent care facility. I understand that MyHealth Urgent Care, P.C., is not responsible for clothing, spectacles, dentures, money, personal electronic devices or other personal articles of value kept in my possession or anywhere on the premises during my time as a patient at your urgent care facility.

Authorizing Signatures

THE PURPOSE OF THIS FORM WAS EXPLAINED TO ME AND I HAD THE OPPORTUNITY TO ASK QUESTIONS.

_____ _____ _____

Signature of Patient **Date** **Time**

_____ _____ _____

Signature of Witness **Date** **Time**

If patient is unable to consent or is a minor, please complete the following:

Patient is a minor _____ years of age or patient is

unable to consent because _____

_____ _____ _____

Signature of Parent, Legal Guardian or Closest Relative **Date** **Time**

_____ _____ _____

Signature of Witness **Date** **Time**