CENTENARY FAMILY & URGENT CARE

New Patient Information and Consent

What is the Reason for your Visit Today?

Patient Information

Name (First, Middle, Last)	Birth Date (00/00/0000)	Age	Social Security #	Birth Gender ____ Male ____ Female
Mailing Address:	Apt #	City, State, ZIP		
Email Address	Primary Phone	Okay to Leave Message? Yes _____ No _____		
Employer (or parent/guardian employer if patient is a minor)		Work Phone		
Primary Care Provider (where you go for your routine medical care)		__ I Do Not Have a PCP __ Centenary Urgent Care is my PCP		
Preferred Language				

Race	Ethnicity
○ White or Caucasian ○ Black or African American ○ Asian ○ Native Hawaiian or Other Pacific Islander ○ American Indian/Alaska Native ○ Other _____	○ Hispanic or Latino ○ Not Hispanic or Latino

Emergency Contact

Contact Name	Phone Number	Relationship to Patient

Guarantor/Responsible Party (person responsible for payment)

Legal Name (First, Middle, Last)	Social Security #	Date of Birth (00/00/0000)

Preferred Pharmacy

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Pharmacy Name	Pharmacy Location

Medical Insurance (Please present your ID and Insurance Card to the Receptionist or Representative)		
PRIMARY Insurance Company Name	Policy Number/Member ID	Group Number
Insured Name	Insured Date of Birth	Patient Relationship to Insured ___Self , ___Spouse, ___Dependent
Insurance Company Address (usually on back of Insurance Card)	**PRIMARY** Insurance Company Phone Number	

SECONDARY Insurance Company	Policy Number/Member ID	Group Number
Insured Name	Insured Date of Birth	Patient Relationship to Insured ___Self, ___Spouse, ___Dependent
Insurance Company Address (Usually on back of Insurance Card)	**SECONDARY** Insurance Company Phone Number	

Workers' Compensation	Is your visit today for a Workers' Compensation Claim? ___ Yes ___ No
Workers' Compensation Billing Address	

I hereby authorize Centenary Family & Urgent Care to speak to a rehabilitation specialist, my employer, my insurance carrier or other professionals involved in my care of rehabilitation, regarding my medical records and the treatment I have received or will receive.

X

_____ _____

Patient or Authorized Person's Signature Date

Accident/Injury information Not Applicable _____

Where did the Injury occur? (example: park) _____

Were you struck by an object? __Yes __ No If YES, what type of Object? _____

Where did you fall? (example: kitchen, bathroom, garage) _____

Where did you fall from? (example: ladder, roof, steps) _____

If you were in a motor vehicle accident, were you the driver or passenger? _____

Authorization of Release of Information

May we leave testing results or referral info in email or voicemail? ___ Yes ___ No

Who may receive information on your behalf regarding testing or referrals? Name: _____

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Patient Consent for Treatment

1. I voluntarily consent to any and all health care treatment and diagnostic procedures provided by (CFUC) Centenary Family & Urgent Care and its associated physicians, clinicians, and other personnel. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations at CFUC.
2. I agree to be contacted via email or SMS with any information related to my visit, like: a patient portal invitation, post-visit satisfaction survey, appointment or checkup reminders, health tips, or new services that related to me or my family.
3. I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment services rendered to me/the patient, treatment and health care operations consistent with CFUC Notice of Privacy Practices.
4. I authorize payment of medical benefits to (CFUC) Centenary Family & Urgent Care physicians or their designee for services rendered.
5. I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.

I have received a copy of the Notice of Privacy Practice and Financial Policy Notice. ___ Yes ___ No

X_____ _____

Patient or Authorized Person's Signature Date