HEALTHCALL MEDICAL CENTER LLC
PLAINFIELD WALK-IN AND MEDICAL CENTER

Patient Name: _____

Patient Address: _____ ZIP:_____ Town:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____
Please Circle Preferred Contact Number

Please Provide Your Email for Our Patient Portal: _____

Date Of Birth: _____

SSN: _____

Primary Care Doctor: _____

Race:
__American Indian or Alaskan Native
__Asian
__Black or African American
__White
__Native Hawiian or Pacific Islander

Ethnicity:
__Hispanic or Latino
__Not Hispanic or Latino

Responsible Party for Minors:_____

Phone Number: _____

Preferred Method of Contact: __Phone __Patient Portal

Is this Work Related? Yes No

Reason For Todays Visit: _____

Employer Name: _____

Insurance Information:

Primary Insurance:

Insurance Holder: Name:_____ Phone #:_____ DOB:_____

Relationship: __Mother __Father __Spouse

Insurance Company: _____ Subscriber #: _____

Secondary Insurance:

Insurance Holder: Name:_____ Phone #:_____ DOB:_____

Relationship: __Mother __Father __Spouse

Insurance Company: _____ Subscriber #: _____

Pharmacy Name and Location:_____

Emergency Contact: _____ Phone Number: _____

Relationship: __Mother __Father __Spouse

Who, if anyone, would you like us to disclose personal health information to? _____

What type of information can we disclose? Treatment Condition Location Billing All

New Patient Health History

Patient Name: _____ Birth Date: ____/____/____

Reason for Today's Visit: _____

Please Describe This Problem: _____

_____

Prior Surgeries	Current/ Prior Illnesses/ Injuries

Please list ALL medications (prescription and not prescription) that you take:

Medication	Dosage:	Medication	Dosage:

Do you take any blood thinning medications such as Vitamin E, Plavix, Coumadin, Aspirin, Eliquis, Xarelto, etc.? __Yes __No

Do you have any allergies? Please Explain Below

Allergic to:	Type: drug/environmental/food	Reaction

Do you smoke? __Never __Current __Former How Much? _____

Type of Smoking: __Cigarette __Marijuana __Chew __Other: _____ How Long? _____

Do you drink alcohol? __No/Never __Socially __Daily __Liquor __Beer/Wine

Occupation: _____ Hand Dominance __Left __Right

Family History: Please describe any familyhealth issues below.

Family History	Good/None/Unknown	Illnesses / Reason for Death
Mother		
Father		
Sibling(s)		
Other Hereditary Illness		

Patient Signature: _____ Date: ____/____/____

Physician Signature: _____ Date: ____/____/____

Rev 5/2017

Health History Form 2

Do you have or have you ever had any of the following:

Symptoms/Illness	No	Yes, Explain	Symptoms/Illness	No	Yes, Explain
Constitutional			**Skin**		
Fever or Chills			Rashes		
Weight Loss			Breast Abnormalities		
			Nipple Discharge		
Hematologic			Last Mammogram		Date: ____/____/____
Hepatitis			Changes in Moles		
HIV/ other Blood Diaseases			Lesions (cysts or boils)		
Bleeding Disorders			History of Keloids		
Endocrine			**Neurological**		
Thyroid			Headaches		
Diabetes			Neurological Problems		
Musculoskeletal			**Genitourinary**		
Arthritis			Genital or Oral Herpes		
Mobility/ Joint Problems			STD's		
			Blood in Urine		
Gastrointestinal			Urinary Tract Infection(s)		
Constipation			Problems with Urination		
Diarrhea			Prostate Problems		
Blood in Stool			Kidney Problems		
Nausea/ Vomiting					
Liver Problems			**Eyes**		
			Vision Changes		
Cardiovascular			Blurry Vision		
Heart Problems			Glaucoma		
DVT (deep vein thrombosis)					
Blood Clots in Lungs			**ENT**		
High Blood Pressure			Hearing problems		
			Sinus Problems		
Respiratory					
Asthma			**Psychiatric**		
COPD			Mood Swings		
Sleep Apnea			Anxiety		
Emphysema			Depression		
Other (please explain): _____					

Patient Signature: _____ Date: _____/_____/_____

Physician Signature: _____ Date: _____/_____/_____

Acknowledgement of receipt of Notice of Privacy Practices

Healthcall Medical Center, LLC
Plainfield Walk-In and Medical Center
Lori Meyers, Office Manager, 860-564-4054

Name of Patient: _____

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

Signed: _____ Date: _____

Printed Name: _____ Phone: _____

For Office Use Only

Signed Form Received by: _____

Acknowledgement Refused.

Efforts to Obtain:

_____

_____

Reasons for Refusal:

_____

_____

Patient Consent and Authorization

Healthcall Medical Center, LLC
Plainfield Walk-In and Medical Center
558 Norwich Rd, Plainfield CT 06374

Consent to Treatment:

I understand that medical treatment of an immediate nature is necessary for the patient and that such medical care, treatment, and procedures will be performed by the independent physicians and by employees of Plainfield Walk In and Medical Center during the hours of operation only. I understand that immediate medical treatment only is being provided and that no responsibility will be taken for long-term patient care or care outside our hours of operation. I hereby grant my authorization and consent to such treatment and procedures, and certify that no guarantee or assurance has been made as to the results, which may be obtained.

Personal Physician:

I am aware that if the provider is not the patients primary care provider or the provider does not participate with the patient's health insurance plan, I will be responsible for any applicable charges.

Third Party Payers:

I hereby give permission to the patient's third-party payer (employer, insurance carrier, workers compensation insurance, etc.) to directly pay Plainfield Walk-In and Medical Center, LLC for services rendered to the patient. It is the patient's ultimate responsibility to understand what their insurance will cover.

Agreement to Pay for Services:

For and in consideration of the care and treatment provided to the patient, I promise to pay Plainfield Walk-In and Medical Center, LLC all charges for services rendered to or on behalf of the patient. This may include any claims denied by the patient's third-party insurance carrier, including any claims denied by workers compensation insurance carrier. I promise to pay any and all collection costs, including attorney fees, allowable by law. Co-payments and deductibles are due at the time of service. A service charge of $10 will be charged if co-payments are not payed within 30 days. There is a $20 service charge for all returned checks.

Release of Medical Information:

I hereby authorize the Plainfield Walk-In and Medical Center, LLC to release private health care information in connection with these services for treatment, payment, and healthcare operations. I also authorize the release of medical information pertaining to any occupational healthcare, provided to the patient at this facility, to the patient's employer, insurance company, and medical provider involved in the diagnosis.

This authorization will remain in effect until revoked by the patient in writing except to the extent that the practice has already made disclosures in reliance upon the patient's prior consent.

My signature below indicates that I have read and understand each of the statements above.

Printed Name: _____

Signature: _____ Date: _____

Relationship (if not the patient):_____