Community Urgent Care of Madison

30694 Hwy 72 Suite E • Madison, AL 35756
P: (256) 230-6130 F: (256) 230-6134

Patient Name: (Last) (First) (Middle)

Date of Birth: Sex: ☐ M ☐ F Race: Ethnicity: Marital Status:

Address: City: State: Zip Code:

SSN#: Home Phone: Cell: Work:

Email Address: Preferred Communication:

Emergency Contact: Phone Number: Relationship:

Employer: Employer Phone: Occupation:

Insurance Carrier: Policy#: Group #:

IF MINOR

Father's Name: Date of Birth:

Address: City: State: Zip Code:

Employer: Employer Phone:

Mother's Name: Date of Birth:

Address: City: State: Zip Code:

Employer: Employer Phone:

PRIVACY COMPLIANCE

Please list the family members or persons, if any, we may inform about your general medical condition and your diagnosis's which might include medical history, treatment, lab reports, x-rays, and treatment and/or reference to any mental or nervous disorders, drug and/or alcohol abuse, or sexually transmitted disease and billing inquiries.

Name: Relationship: Phone:

Name: Relationship: Phone:

CAN CONFIDENTIAL MESSAGES BE LEFT ON HOME OR CELL VOICEMAIL? **Yes** **No**

I hereby authorize Community Urgent Care of Madison to furnish to my primary physician and insurance company(s) all information which said physician or insurance company (s) may request. I hereby assign to Community Urgent Care of Madison all money to which I am entitled for medical/surgical expense relative to the services rendered but not to exceed my indebtedness to the professional company. I understand that I am financially responsible for all charges, whether paid, by said insurance. I hereby waive claims of exemption under the State of Alabama. I understand
There will be a $30.00 fee for returned checks. I agree to pay 27% of principal balance for collection costs should account be placed with a collection agency or attorney, plus court costs expended. I hereby give permission to Community Urgent Care of Madison to contact me via the numbers I have provided on issues associated with my account to include cellular numbers connected with me or my account. I understand that Community Urgent Care of Madison has a policy of random urine drug testing for all patients who are prescribed scheduled medications. Failure to provide a sample will disqualify me from receiving treatment at this facility. I permit a copy of this authorization to be used in place of this original.

Patient's Signature: Date:

Parent and/or Guardian's Signature: Date:

WOULD YOU LIKE A COPY OF OUR PRIVACY PRACTICES? **Yes** **No**

PATIENT MEDICAL HISTORY

Please select from the list below if you have ever been diagnosed with the following:

	Anemia		Fibromyalgia		Hypothyroidism		Vascular Problems
	Blood Clots or Free Bleeding		Gerd		Hyperthyroidism		Other
	Cancer		Glaucoma/Retinopathy		Joint Disease/Arthritis		
	Chronic Pain		Gout		Kidney Disease		
	Chronic Sinusitis		Heart Disease		Lung Disorder		
	Depression		Hepatitis		Migraine		
	Diabetes		High Blood Pressure		Seizures		
	Diverticulitis		High Cholesterol		Skin Disorders		
	Erectile Dysfunction		HIV/Aids		Stroke		

Please list any family member (father, mother, sibling, etc) that have been diagnosed with any of the conditions listed above:

Condition: _____ Family Member: _____

Condition: _____ Family Member: _____

DO YOU HAVE ANY ALLERGY TO ANY MEDICATION(S)? **Yes** **No** If, yes please list medications below:

_____

TOBACCO USE: ☐Non-Smoker ☐ Current Smoker ☐Former Smoker ☐Smokeless Tobacco

ALL OF THE FOLLOWING WILL BE DOCUMENTED IN THE EMR DURING THE PATIENT'S TRIAGE PROCESS:

- **MEDICATIONS (PRESCRIBED/OVER THE COUNTER/DOSAGE AND FREQUENCY OF MEDICATION)**
- **SURGERIES/PROCEDURES/HOSPITALIZATIONS**
- **VACCINES**

Patient's Signature: _____ Date: _____

Parent/Legal Guardian: _____ Date: _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ SSN: _____

Date of Request: _____ Type of Records Requested: _____

PLEASE SEND MEDICAL RECORDS UPON REQUEST

I AUTHORIZE COMMUNITY URGENT CARE OF MADISON TO RELEASE OR RECEIVE INFORMATION

Name of Provider/Facility: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

I HEREBY AUTHORIZE THE RELEASE OF ANY AND ALL MEDICAL INFORMATION. INCLUDING DIAGNOSIS, TREATMENT, PROGNOSIS, ETC. OF THE INJURIES AND/OR ILLNESS RECEIVED BY THE ABOVE NAMER PERSON ON AND SUBSEQUENT TO THE DATE OF THE INJURIES AND/OR ILLNESS. AUTHORIZATION IS KEPT ON FILE UNLESS REVOKED IN WRITING.

Patient's Signature: _____ Date: _____

Parent/Legal Guardian: _____ Date: _____

Community Urgent Care of Madison
30694 Hwy 72 Suite E
Madison AL 35756
P:256-2306130 F:256-230-6134

Consent to Treat

Patient Name:_____Date of Birth:_____

I authorize the providers at Community Urgent Care of Madison to perform necessary medical examinations and tests to diagnose and treat my health conditions.

I understand that I have the right to discuss any treatment with my provider and I am encouraged to ask questions about any concerns I may have.

I understand that Community Urgent Care of Madison will sometimes send outside labs to determine the best treatment we can provide for you and your family. If you do not want any outside labs done please let the back staff know.

I understand that I am responsible for any bill that I may receive that insurance does not cover.

_____

Patient Signature date

_____

Parent/Guardian Signature (if patient is a minor) date