EDMOND URGENT CARE
1101 NW 178TH ST SUITE B
EDMOND, OK 73012
405-285-2161

****PLEASE GIVE YOUR DRIVER'S LICENSE/STATE ID AND YOUR INSURANCE CARD TO THE RECEPTIONIST TO COPY FOR YOUR CHART.****

Patient Information

NAME — LAST _____ FIRST _____ MI _____

AGE _____ DATE OF BIRTH _____ SS # _____

GENDER M F MARITAL STATUS SINGLE / MARRIED / DIVORCED / WIDOWED / OTHER

ADDRESS INFORMATION — STREET _____

APT/LOT # _____ CITY/STATE/ZIP _____

EMAIL _____

PHONE — HOME _____ WORK _____

CELL _____ OTHER _____

EMERGENCY CONTACT — NAME _____ RELATION TO PATIENT _____

HOME PHONE _____ CELL PHONE _____

ADDRESS

YOUR EMPLOYER — NAME _____

STREET _____ CITY/STATE/ZIP _____

PHONE _____ EXT _____

BILLING INFORMATION

RESPONSIBLE PARTY — LAST _____ FIRST _____ MI _____

DATE OF BIRTH _____ SS # _____

MISCELLANEOUS — WHO REFERRED YOU? _____ PHONE _____

PRIMARY INSURANCE — NAME _____ **SECONDARY INSURANCE** NAME _____

POLICY # _____ POLICY # _____

OFFICE USE ONLY — INSURANCE PH # _____ Eff Date _____

COPAY _____ DEDUCT _____ MET _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependants(s), have insurance coverage with _____ and assign directly to EDMOND URGENT CARE all insurance benefits, if any, otherwise payable to me for services rendered . I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named physician may use my health care information and may disclose such information to the above named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefit payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative **Date**

_____ _____
Please print name of Patient, Parent, Guardian, or Personal Representative **Relationship to Patient**

EDMOND URGENT CARE

Name:_____ Date of Birth:_____

Consent for Provider Services

1. **Annual Consent for Services:** I consent to the services that may be performed by an Edmond Urgent Care physician/provider. I understand I can withdraw my consent at any time.

2. **Financial Agreement:** I agree to accept financial responsibility for all services provided to me by Edmond Urgent Care. I also agree to promptly pay all hospital and provider bills, in accordance with the applicable rates and terms, which can be modified by agreement between the facility or provider and my health care insurance company. Should an account be referred to an attorney or collection agency for collection, I will pay attorney's fees and collection expenses. I understand that if my account is delinquent, it will incur interest at the legal rate. Edmond Urgent Care will provide a medical screening exam to anyone in need of emergency treatment, regardless of ability to pay.

3. **Assignment of Insurance Benefits:** I assign and authorize direct payment to Edmond Urgent Care of all insurance and plan benefits related to services provided by Edmond Urgent Care. By paying Edmond Urgent Care, my insurance company or employer is fulfilling its obligations under my health insurance policy, or my employer is fulfilling its obligations as required by law. I also understand that I am financially responsible for charges not paid according to this assignment.

4. **Medicare Assignment:** I certify that the information given by me in applying for payment from any third party payer, including payment under Title XVIII of the Social Security Act, is correct. I request that payment of authorized benefits be made in my behalf, and I authorize the Social Security Administration Office of the Department of Health and Human Services to release information regarding my eligibility for coverage under Medicare Part A and Part B, including but not limited to the effective date of such coverage. I also authorize Edmond Urgent Care to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim.

5. **Legal Relationship between facility and Provider:** I understand that when I am seeking treatment, I am under the care and supervision of the attending provider and it is the responsibility of the facility and nursing staff to carry out his/her instructions. It is the responsibility of my provider to obtain my informed consent, when required, for specific medical treatment, special diagnostics or therapeutic procedures, or facility services provided to me under instruction of the provider.

6. **Rules and Regulations:** I understand that my visitors and I must obey all rules and regulations. I understand that in the event all rules and regulations are not followed, Edmond Urgent Care may pursue corrective action.

7. **Notice of Privacy:** I acknowledge that I have received a copy of the Notice of Privacy Practices (NPP), which describes when Edmond Urgent Care may use or disclose information for treatment, payment and health care operations. The NPP is considered part of the Conditions of Admission by this reference. I understand that this notice is only provided the first time I receive services from Edmond Urgent Care and is otherwise available upon request.

8. **Demographic Information:** I have reviewed the demographic information listed for me and it is correct. I am aware that I need to inform Edmond Urgent Care of any changes as soon as possible.

9. **Independent Contractor/Providers:** I understand that separate bills may be sent for professional services from non-Edmond Urgent Care providers such as radiology, laboratory, and DME, in addition to the Edmond Urgent Care bill.

10. **Phone Calls:** I authorize Edmond Urgent Care and its collection agencies to contact me, or a representative I appoint, about my account, including using any contact information or cell phone numbers that I have provided or will provide, or that is available to Edmond Urgent Care from third parties. I authorize contact with me by telephone or voice messages and authorize the use of automated dialing technology and pre-recorded messages. I agree such contact will not be "unsolicited" for purposes of local, state or federal law.

11. **Patient Self Determination Act:** I have an Advanced Directive? ___YES ___NO

A copy of this form shall have the same force and effect as the original. The undersigned is the patient or is duly authorized to act on behalf of the patient to execute and accept the terms thereof. A copy of the executed form is available upon request.

Date: _____ Time: _____ Signature: _____

If signed by other that patient, indicate relationship: _____

Witness: _____

Medical Release Form

Effective April 14, 2003 (due to federal guidelines under HIPPA) we are required to have a release signed by the patient before we can give out any medical or financial information to any person other than the patient.

Please list below the names, relationship, and phone numbers of any authorized individuals (spouse, family members, friends, caregivers, ect.) that we may discuss your **medical or financial information** with.

NAME	RELATIONSHIP	PHONE #
1.		
2.		
3.		

OR

If you wish not to have any medical or financial information discussed with anyone other than yourself, please sign here:

_____ _____

Patient/Guardian Signature Date

The above information is private and confidential and will be placed in your medical chart. The information on this form will remain valid until we are notified otherwise.

****

May we leave medical information on your "home" answering machine? YES NO

May we leave appointment information on your "home" answering machine? YES NO

_____ _____

Patient/Guardian Signature **Date**

We require all patients to update their Medical History Form at least once per year or as their medical history changes.

EDMOND URGENT CARE

NAME:_____ **DOB:**___/___/___ **TODAY'S DATE:**___/___/___

What symptoms are you having today?_____

If female, is there any chance that you might be pregnant? YES or NO Date of LMP___/___/___ **or N/A**

Please list the medications you are currently taking, their dosages, and how many times per day you take them:

_____

_____

_____

Do you have any ALLERGIES or intolerances to drugs, latex, food, insects, etc? YES or NO
If YES, provide a description of each allergy including the type of reaction:_____

_____

Please circle any of the following medical problems that you have had OR circle NONE

General

Serious Infections
Diabetes Mellitus
Rheumatic Fever
HIV Infection
Cancer (Where?)
_____

Cardiovascular

High Blood Pressure
Congestive Heart Failure
Heart Murmur
Heart Valve Disease
Angina
Heart Attack
High Cholesterol
Abnormal Heart Rhythm
Blood Clots in Veins
Blocked Arteries in Neck
Blocked Arteries in Legs

Respiratory

Asthma
Pneumonia
Emphysema
Blood clot in lungs
Sleep Apnea

Musculoskeletal

Osteoporosis
Rheumatoid Arthritis
DJD
Fibromyalgia
Neck Pain (Hern. Disk)
Back Pain (Hern. Disk)

Lymphatic/Hematologic

Thyroid Goiter
Over Active Thyroid
Under Active Thyroid
Transfusions
Anemia

Gastrointestinal/Genitourinary

Stomach Ulcers
Ulcerative Colitis
Crohn's Disease
Intestinal Bleeding
Diverticulitis
Colon Polyps
Irritable Bowel Disease
Hepatitis
Cirrhosis
Pancreatitis
Gallstones
Kidney Stones
Kidney Failure
Prostate Disease
Endometriosis
UTI
STDs

Neurological/Psychiatric

Chronic Vertigo
Peripheral Nerve Disease
Migraine Headaches
Stroke
Multiple Sclerosis
Depression
Anxiety
Schizophrenia
Bipolar Disorder

Skin/Breast

Acne
Eczema
Psoriasis
Fibrocystic Breast Disease

Head/Eye/Ear/Nose

Glaucoma
Allergies/Hay Fever
Frequent Ear Infections
Frequent Sinus Infections

Other Medical Problems_____

_____

_____

PHARMACY PREFERENCE LOCATION/ADDRESS

_____

Patient Name: _____ **DOB** _____

Please circle or list any surgical procedures that you have had or circle NONE

Angioplasty	Colonoscopy	Neurosurgery
Appendectomy	Coronary Bypass	Other Vascular Surgery
Back or Neck Surgery	Ear/Tubes Surgery	Ovary Removed
Bladder Surgery	Eye Surgery	
Thyroid Surgery		
Carotid Artery Surgery	Inguinal Hernia	Tonsillectomy
Carpal Tunnel Surgery	Knee Surgery	Trauma Related Surgery
Chest/Lung Surgery	Musculoskeletal Surgery	Tubal Ligation

Other: _____

_____

Circle and fill in the information that best describes your social health issues:

Tobacco Use	Drug Use	Alcohol Use	Caffeine Use
never/past/active	never/past/active	never/past/active	never/past/active
cigarette/cigar/pipe	cocaine/marijuana	liquor/wine/beer	coffee/tea/soda
snuff/dip/chew	heroin/amphetamine	____drinks per	___cans/cups daily
start___stop___	barbiturate/LSD/PCP	day/week/month	
packs per day___	IV drug abuse/drug rehab	AA/alcohol rehab	

Circle or list any major illnesses your family members have had (Mother, Father, Sisters, Brothers, Children, Grandparents)

Anemia	Epilepsy	Liver Disease	Thyroid Disease
Breast Cancer	Heart Disease	Neurological Disorder	Tuberculosis
Colon Cancer	Hemophilia	Osteoporosis	_____
Diabetes	High Blood Pressure	Ovarian Cancer	_____
Emphysema	Kidney Disease	Prostate Cancer	_____

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FOR OFFICE USE ONLY

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Time **BP** / **Pulse** **Sat** %

Weight **Height** **Resp** **Temp**

MED	DOSE	ROUTE	SITE	TIME
1.				
2.				
3.				
4.				

RADIOLOGY EXAM

_____

_____

_____

URINE DIPSTICK

Glucose:_____

Ketones:_____

S.G.:_____

Blood:_____

pH:_____

Protein:_____

Nitrates:_____

Leukocytes:_____

ADDITIONAL NOTES:_____

_____

_____

Pain Level (0-10): Pre Med

Post Med

COVID 19

POSITIVE

NEGATIVE

MONO

POS NEG

Strep A

POS NEG

Influenza

POS NEG

A OR B

RSV

POS NEG

HEMOCCULT

POS NEG

HCG

POS NEG

URINE OR SERUM