TOTAL URGENT CARE

Workplace Health Registration Form

Please fill out form completely and legibly.

Patient's Full Name: _____

Date of Birth: _____ Age: _____ Sex: M F

Street Address: _____

City, State, Zip: _____

Email Address: _____

Phone: _____ Cell Phone: _____

Carrier: Verizon AT&T Sprint T-Mobile Boost Mobile

Nextel Other: _____

Preferred Contact Method: Phone Text Email Mail

Would you like to be reminded of your appointment? Yes No

How many days before?: _____ day(s)

Primary Care Physician: _____

Physician Phone:_____

How did you hear about us?: _____

Ethnicity: Hispanic or Latino Non-Hispanic or Latino

Race: American Indian or Alaskan Native Asian

Black or African American White

Native Hawaiian or Pacific Islander

Social Security No: _____

Marital Status: Child Single Married

Divorced Widowed Separated

Emergency Contact: _____

Emergency Phone: _____

Relationship to Patient: _____

Injured at?: Work Home Other:_____

Employer: _____

Employer Address: _____

_____

Employer Phone No: _____

Employer Contact: _____

Motor Vehicle Accident?: Yes No

Date of Injury/Illness: _____ Time: _____(a/p)

Date last worked: _____ (m/d/yy)

Occupation: _____

Reason for Visit: Physical Drug/Alcohol Screening

Immunization Other: _____

In your own words, describe how injury/illness occurred:

_____

_____

_____

CONSENT FOR TREATMENT:

I CERTIFY THAT THE INFORMATION GIVEN BY ME IS CORRECT AND I HEREBY CONSENT TO AND AUTHORIZE THE PERFORMANCE OF TREATMENT AND/OR MEDICAL OR SURGICAL PROCEDURES OR SERVICES WHICH MAY BE CONSIDERED NECESSARY OR ADVISABLE BY THE PHYSICIAN (IF APPLICABLE). I GRANT TOTAL URGENT CARE AUTHORITY TO PERFORM NECESSARY EXAMINATION AND TESTING TO INCLUDE TESTS TO DETECT THE PRESENCE OF DRUGS AND/OR ALCOHOL IF REQUESTED BY MY EMPLOYER. I UNDERSTAND AND AGREE THAT ALL RESULTS WILL BE RELEASED TO MY EMPLOYER.

ASSIGNMENT OF INSURANCE BENEFITS AND RELEASE OF INFORMATION: TOTAL URGENT CARE MAY DISCLOSE ALL OR ANY PART OF MY MEDICAL RECORD TO ANY PERSON OR CORPORATION WHICH IS OR MAY BE LIABLE TO TOTAL URGENT CARE FOR ALL OR PART OF ITS CHARGES, INCLUDING BUT NOT LIMITED TO, INSURANCE COMPANIES (HEALTH AND AUTO), WORKERS' COMPENSATION CARRIERS, OR MY EMPLOYER. I HEREBY AUTHORIZE MY INSURANCE COMPANY TO PAY BENEFITS FOR TREATMENT TO TOTAL URGENT CARE.

Patient or representative signature: _____ Date: _____

TOTAL URGENT CARE
Medicine the way it should be…friendly and affordable!!!

2120 Emmorton Park Road, Suite E
Edgewood, MD 21040
Tel: (410) 612-0374 Fax: (410) 612-9174

Acknowledgement of Offer to Receive or Receipt of Notice of Privacy Practices

Your Personal Health Information is Kept Private by Total Urgent Care

In accordance with the federal HIPAA regulation, we are required to follow very strict regulation as it pertains to your health information. Please see our Notice of Privacy Practices for more specifics on this issue.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting Carmen Anderson. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required in changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

I have been offered a copy of the Notice of Privacy Practices for **Total Urgent Care**.

Name of patient (please print clearly) **X**_____

Signature of Patient/Guardian **X**_____

Date **X**_____

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Patient History

Injury/Urgent Care _____ Pre-Placement Exam _____ Periodic/Annual Exam _____ Private Exam _____ **Date:** _____

Employer _____ Occupation _____

Name _____ Date of Birth _____

Name of Primary Care Physician_____

PRESENT MEDICAL HISTORY

1. Why are you here today? _____
2. If you are here for an injury or illness, when did accident or illness occur?_____
3. Have you ever had similar symptoms before? ☐ YES ☐ NO If so, when?_____

PAST MEDICAL HISTORY

Have you now or ever had any of the following? (Please check all that apply)

	YES	NO		YES	NO		YES	NO
Mouth or Throat Disease	☐	☐	Fractures	☐	☐	Sinus Problems	☐	☐
Chest Conditions	☐	☐	Dislocations	☐	☐	Venereal Disease	☐	☐
Tuberculosis	☐	☐	Amputations	☐	☐	Are you pregnant?	☐	☐
Diabetes	☐	☐	Ganglions	☐	☐	Painful menstrual periods	☐	☐
Asthma/Hay Fever	☐	☐	Allergies	☐	☐	Foot Problems	☐	☐
Heart Problems/Disease	☐	☐	Epilepsy or Fainting Spells	☐	☐	Sleeping Problems	☐	☐
Stomach, Gall Bladder/			Skin Problems/Disease	☐	☐	Hearing/Vision Problems	☐	☐
Intestinal Trouble	☐	☐	Occupational Disease	☐	☐	Frequent Headaches	☐	☐
Kidney Trouble	☐	☐	Hemorrhoids	☐	☐	Frequent Colds	☐	☐
Rupture or Hernia	☐	☐	High Blood Pressure	☐	☐	Any claims for compensation		
Shortness of Breath	☐	☐	Back Pain/Injury	☐	☐	or Disability?	☐	☐
Varicose Veins	☐	☐	Knee Pain	☐	☐	Ever employed in Mine,		
Rheumatism or Arthritis	☐	☐	Wrist Pain	☐	☐	Quarry, Glass works, Foundry,		
Pneumonia/Pleurisy	☐	☐	Ulcers	☐	☐	Sandblasting, Chemical		
Chronic Cough	☐	☐	Nervous Disorders	☐	☐	Industry or exposed to		
Bronchitis	☐	☐	Abnormal Fatigue	☐	☐	asbestos products?	☐	☐
Frequent Indigestion	☐	☐	Poliomyelitis	☐	☐			

1. Any significant family medical conditions (If yes, please list)? _____
2. Show year and diagnosis of your last illness. _____
3. List ALL drugs or medications you use regularly: _____

   _____
4. When was your last tetanus shot? _____
5. ALLERGIES: List any allergies you may have. _____
6. VISION: Do you wear eyeglasses or contacts constantly? _____ Only for reading? _____
7. SOCIAL HISTORY: Do you have a history of drug use? _____
   Do you drink alcoholic beverages? _____ How many a week? _____
   Do you smoke cigarettes? _____ cigars? _____ pipe? _____
   How many per day? _____ For how long? _____
8. SURGERIES and/or HOSPITALIZATIONS: List dates and reasons for all surgeries and/or hospitalizations.

_____

MEDICAL RELEASE OF INFORMATION:

I HEREBY AUTHORIZE TOTAL URGENT CARE TO SEND A REPORT OF MY EXAMINATION TO THE COMPANY FOR WHICH THE EXAMINATION IS BEING CONDUCTED OR RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY TREATMENT TO MY INSURANCE COMPANY. I FULLY RELEASE TOTAL URGENT CARE FROM ALL CLAIMS AND DAMAGES IN CONNECTION WITH FURNISHING THE REPORT TO THE SAID COMPANY OR INSURANCE COMPANY. I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE DIRECTLY TO TOTAL URGENT CARE FOR ALL SERVICES RENDERED. MY SIGNATURE BELOW INDICATES THAT I HAVE TRUTHFULLY ANSWERED ALL QUESTIONS.

Employee/Patient Signature _____ Reviewing Staff Member _____

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Occupational History

Name:_____

Date of Birth: _____ **Reason for Exam:** □ Post Offer □ Annual □ Injury □ Other

Please check any of these items to which you have had exposures or needed medical treatment:

□ Asbestos	□ Dust	□ Vapors/Gases	□ Electroplating
□ Benzene	□ Radiation	□ Vibrations	□ Hazardous Waste
□ Blood/Body Fluids	□ PCB/PBB	□ Heat/Cold Exposure	□ Lead
□ Cadmium	□ Excessive Noise	□ Pesticides	□ Arsenic
□ Mercury	□ Methylene Chloride	□ Sandblasting	□ Solvents

□ Other (please specify): _____

If YES to any of the above, describe below including a complete description of the exposure, dates of occurrences, and the names of physicians who treated you. Also, please list place of employment if exposure occurred in a work environment.

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1. Have you ever been injured on the job in any way?	□ Yes	□ No
2. Have you ever gotten sick in any way from something you worked with on the job?	□ Yes	□ No
3. Has your work ever caused problems with your joints (wrists, hands, knees, etc.) your back or skin?	□ Yes	□ No
4. Have you had any hobbies or jobs in which you use chemicals, metals, loud machines or tools, firearms, music, amplifiers, or other hazardous substances?	□ Yes	□ No
5. Have you ever claimed Workers' Compensation Benefits?	□ Yes	□ No
6. Have you ever terminated any job for health reasons?	□ Yes	□ No
7. Have you ever had to transfer from one job to another or change job duties for health reasons?	□ Yes	□ No
8. Have you ever been refused any job for health reasons?	□ Yes	□ No
9. Has a doctor ever placed restrictions on your lifting, bending, twisting, walking, standing, sitting, or using your hands, arms, or back?	□ Yes	□ No
10. Have you ever had a back injury or experienced back pain or back strain?	□ Yes	□ No
11. Have you ever had x-rays of your back?	□ Yes	□ No
12. Have you ever had surgery of any kind?	□ Yes	□ No
13. Have you ever been advised to have surgery that wasn't completed?	□ Yes	□ No
14. Are you currently under work restrictions?	□ Yes	□ No
15. Do you limit your personal activities due to pain, inability, or any other reason?	□ Yes	□ No
16. Have you ever received instructions on proper lifting?	□ Yes	□ No

If YES to any of the above, describe below including a complete description of the exposure, dates of occurrences, and the names of physicians who treated you. Also, please list place of employment if exposure occurred in a work environment.

_____

_____

I certify the information contained in this record is correct and complete to the best of my knowledge and belief. I understand that knowingly making a false statement in this record may have consequences such as denial of workers' compensation claims, and withdrawal of offers of employment. I understand that Total Urgent Care will keep this medical history confidential.

Signature of Patient/Guardian: **X** _____ **Date:**_____

Signature of Clinician: _____ **Date:**_____