

**ACCESS HEALTH**

*Concierge Care*

Elizabeth Flower, MD



**SEBASTOPOL**

**URGENT CARE**

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555 Petaluma Ave, Ste B

Sebastopol, Ca. 95472

**Patient Information**

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ Social Security# \_\_\_\_\_

Reason for visit today:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When did symptoms (problems) begin:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Primary Insurance Information**

Insurance Company: \_\_\_\_\_ ID# \_\_\_\_\_

GRP# \_\_\_\_\_

Primary Subscriber Name: \_\_\_\_\_

Primary Subscriber DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Secondary Insurance Information**

**Insurance Company:** \_\_\_\_\_ **ID#** \_\_\_\_\_

**GRP#** \_\_\_\_\_

**Employer Information**

**Employer Name:** \_\_\_\_\_ **Ph#** \_\_\_\_\_

**Address:**

\_\_\_\_\_

**Emergency Contact**

**Name:** \_\_\_\_\_ **Ph#** \_\_\_\_\_

**Relation to Patient:** \_\_\_\_\_

**Pharmacy Information**

**Pharmacy Name:** \_\_\_\_\_ **Ph#** \_\_\_\_\_

**Health History**-please list any current conditions, past conditions, hospitalizations or abnormal test results (For example: Arthritis, high cholesterol, pregnancies, depression, pap smear, hay fever)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**Surgeries and Procedures**-please include dates if possible (For example: C-Section, heart stenting, cataract surgery, endoscopy, vasectomy)

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**Current Medications**-please list both prescription and over the counter medications and supplements (For example: Lipitor 20mg once a day, aspirin 325mg as needed)

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**Medication Allergies**-please describe what happened (For example: Penicillin gave me hives)

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**Social History:**

**Alcohol:** Drinks per day \_\_\_\_\_, per week \_\_\_\_\_, I quit (when) \_\_\_\_\_

**Tobacco:** Packs per day \_\_\_\_\_, how many years \_\_\_\_\_, I quit (when) \_\_\_\_\_, Never Smoker \_\_\_\_\_

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AUTHORIZATION TO MAIL, CALL OR E-MAIL: I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize Access Health Sebastopol Healthcare Group representative or my physician to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Access Health Sebastopol Healthcare Group to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SERVICES: I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT: I hereby consent to evaluation, testing, and treatment as directed by my Access Health Sebastopol physician or his or her designee.

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Patient Name: (please print) \_\_\_\_\_

GUARANTOR SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
(If different from patient)

GUARANTOR NAME: (please print) \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_