

Account # _____

Date _____

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Patient Information

SSN: _____

Patient Name (First, Middle, Last): _____

Nick Name: _____ Date of Birth: _____ Sex: F M

Mailing Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____

Email: _____

Marital Status: Child Married Single Separated Widow Divorced (circle one)

Employer Name: _____ Employer #: _____

Primary Care Physician: _____

Phone: _____ Fax: _____

Emergency Contact: _____ Phone: _____

Relationship to Patient: _____

Race: _____ Ethnicity: ___Hispanic ___Non-Hispanic

Preferred Language: _____

Insurance Information

Policy Holder Name: _____ Date of Birth: _____

Address (if different from above): _____

Relation to Patient: _____

Insurance: _____ Member ID #: _____

Policy/Group #: _____

How did you hear about Lifeguard Urgent Care? (Check one) Friend Relative Drive by Online Lifeguard Flyer School Pharmacy Healthcare Provider Other _____

PATIENT REGISTRATION FORM

Acknowledgement of Notice of Privacy Practices

I have been given the opportunity to read and have had any questions addressed concerning Lifeguard Urgent Care's Notice of Privacy Practices.

- I give my permission to have messages concerning my care left on my voicemail.
- I do NOT give my permission to have messages concerning my care left on my voicemail.

Patient/Patient Representative Signature: _____ Date: _____

Insurance Authorization and Assignment

I request that the payment of authorized Medicare/insurance benefits be made on my behalf for any services furnished to CMS/insurance carriers and its agents any information needed to determine these benefits or benefits related to services. I hereby authorize Lifeguard Urgent Care garnish information to CMS/insurance carriers concerning my medical condition, illness and treatment to determine the benefits for related services. I hereby authorize (assign) my insurance carrier/CMS to make payment directly to Lifeguard Urgent Care for medical/diagnostic or surgical benefits payable for the services rendered. I understand that any unpaid balance not covered by this policy will be paid by me. I understand and agree (regardless of my insurance status), that I am ultimately responsible for the balance of any professional services rendered. I understand that I am responsible for any charges incurred if my account is sent to a collection agency and for any returned checks. I understand that CMS and/or other insurance carriers do not cover all office services/procedures. I agree to take full responsibility for any unpaid balances and that such payment will be made to Lifeguard Urgent Care for services rendered. I certify that the information I have given here is true and correct to the best of my knowledge. I will also notify you (the office) of any changes in the above information.

Signature: _____ Date: _____

Consent for Medical Treatment

FOR ADULTS

I, the patient or authorized patient representative, consent to any medical examination, evaluation and treatment regarding any illness, injury, and/or health concern affecting me at any time I present to Lifeguard Urgent Care for medical treatment. These services may include, but are not limited to laboratory procedures, x-ray examinations, and medical and/or surgical treatment procedures.

Signature of Patient/Patient Representative: _____ Date: _____

FOR MINOR PATIENTS

I, the undersigned attest that I am the custodial parent or legal guardian or the above referenced minor, and hereby authorize Lifeguard Urgent Care to administer treatment, as it so deems necessary to the minor.

Name of Custodial/Legal Guardian: _____

Relationship to Minor: _____

Custodial/Legal Guardian Signature: _____ Date: _____

HIPAA Privacy Notice

I have reviewed a copy of Lifeguard Urgent Care's Privacy Notice and acknowledge this by signing below (a copy will be furnished upon request).

Signature: _____ Date: _____

Patient Name _____

DOB: _____

Pharmacy Name: _____ Cross Streets: _____

FAMILY HISTORY

The following questions pertain to your family:

Father

Mother

	<u>Yes</u>	<u>No</u>	<u>Unk</u>		<u>Yes</u>	<u>No</u>	<u>Unk</u>	
Cardiovascular Disease <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brain Aneurysm <input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Brain Aneurysm		<input type="checkbox"/>	<input type="checkbox"/>

Medications

Name	Quantity	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies

Name	Type (food/drug)	Reaction
_____	_____	_____
_____	_____	_____
_____	_____	_____

WOMEN ONLY

Are you pregnant? _____ If yes, what is your due date? _____

Date of Last Period _____

PATIENT MEDICAL HISTORY

SURGICAL HISTORY

I have no surgical history

- Adenoids (w/o tonsils)
- Tonsils (w/o adenoids)
- Adenoids & Tonsillectomy
- Appendectomy
- Back – Reason _____
- Cancer (Type): _____
- Cataract(s)
- C-Section: # of times _____
- Gallbladder
- Ear Tubes: # of times _____
- Heart Bypass
- Heart Stents
- Hysterectomy
- Mastectomy
- Pacemaker
- Tubal Ligation
- Vasectomy
- Other _____
- _____
- _____
- _____
- _____

MEDICAL HISTORY

I have no medical history

- A. Fib
- Acid Reflux
- ADD / ADHD
- Anxiety
- Arthritis / DJD
- Asthma
- CHF
- COPD / Emphysema
- Crohn's
- CVA / Stroke
- Dementia
- Depression
- Diabetes
- Diverticulitis
- Endometriosis
- Fibromyalgia
- Gallstones
- Glaucoma
- Gout
- Heart attack
- Heart Disease
- Hepatitis
- High Blood Pressure
- High Cholesterol
- Hypothyroid
- Kidney Disease
- Kidney Stones
- Migraines
- Neuropathy
- Parkinson's
- Pulmonary Embolism
- Rheumatoid Arthritis
- Sciatica
- Sleep Apnea
- TIA
- Other _____
- _____
- _____
- _____

SOCIAL HISTORY

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Tobacco Use	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol	<input type="checkbox"/>	<input type="checkbox"/>
Street/Unprescribed Drugs	<input type="checkbox"/>	<input type="checkbox"/>	Recent Travel	<input type="checkbox"/>	<input type="checkbox"/>