

# LIFEGUARD URGENT CARE

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## PATIENT REGISTRATION FORM

Account # \_\_\_\_\_

Date \_\_\_\_\_

NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

### 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: \_\_\_\_\_

### PHARMACY

Pharmacy Name: \_\_\_\_\_ Cross Streets: \_\_\_\_\_

### HOW DID YOU HEAR ABOUT LIFEGUARD URGENT CARE? (CHECK ONE)

Friend  Relative  Drive by  Online  Lifeguard Flyer  School

Pharmacy  Healthcare Provider  Other \_\_\_\_\_

## ACKNOWLEDGMENT 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.**

You expressly consent and agree that, in order to discuss or service your account(s) or to collect amounts you may owe Lifeguard Urgent Care, and its officers, agents, affiliates, employees, and any affiliated or associated service providers and any third-party debt collection agency associated therewith (collectively, We may contact you by telephone at any telephone number associated with the Accounts, including wireless telephone numbers, which could result in charges to you. You expressly consent and agree that We may also contact you by sending text messages, emails, using any e-mail address you provide to us, or by pre-recorded or artificial voice or voice messages, automatic dialing methods, systems, or devices, and pre-recorded or artificial voice prompts at any telephone number associated with the Accounts, including wireless or mobile telephone numbers, regardless of whether you incur charges as a result.

**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

**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:** \_\_\_\_\_

**MEDICAL HISTORY**

The following questions pertain to the Patient's Parents:

**FATHER**

**MOTHER**

	Yes	No	Unk
Cardiovascular Disease	<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"/>
High Blood Pressure	<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"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No	Unk
Cardiovascular Disease	<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"/>
High Blood Pressure	<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"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**MEDICATIONS**

Name	Quantity	Frequency
_____		
_____		
_____		
_____		
_____		
_____		
_____		
_____		

**ALLERGIES**

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

**WOMEN ONLY**

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

Date of Last Period \_\_\_\_\_

PATIENT MEDICAL HISTORY

PLEASE CHECK ALL THAT APPLY

SURGICAL HISTORY

- I have no surgical history
- or*
- 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 \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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MEDICAL HISTORY

- I have no medical history
- or*
- 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 Stone
- Migraines
- Neuropathy
- Parkinson's
- Pulmonary Embolism
- Rheumatoid Arthritis
- Sciatica
- Sleep Apnea
- TIA

Other \_\_\_\_\_

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SOCIAL HISTORY

- |                           |                          |                          |               |                          |                          |
|---------------------------|--------------------------|--------------------------|---------------|--------------------------|--------------------------|
|                           | Yes                      | No                       |               | Yes                      | No                       |
| 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"/> |