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 no 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	Yes	No	Unk
Cardiovascular Disease	☐	☐	☐
High Cholesterol	☐	☐	☐
Cancer	☐	☐	☐
High Blood Pressure	☐	☐	☐
Lung Disease	☐	☐	☐
Brain Aneurysm	☐	☐	☐
Diabetes	☐	☐	☐
Alzheimer's	☐	☐	☐
Psychiatric	☐	☐	☐

MOTHER	Yes	No	Unk
Cardiovascular Disease	☐	☐	☐
High Cholesterol	☐	☐	☐
Cancer	☐	☐	☐
High Blood Pressure	☐	☐	☐
Lung Disease	☐	☐	☐
Brain Aneurysm	☐	☐	☐
Diabetes	☐	☐	☐
Alzheimer's	☐	☐	☐
Psychiatric	☐	☐	☐

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	☐	☐	Alcohol	☐	☐
Street/Unprescribed Drugs	☐	☐	Recent Travel	☐	☐