



**Patient Information Form**

Check here if you are updating your information due to a new address or new insurance.

**PATIENT INFORMATION**

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Name \_\_\_\_\_  
*Last First MI*

Address \_\_\_\_\_  
*Street Apt # City State Zip*

Home Phone (\_\_\_\_) \_\_\_\_\_ Alternate Phone (\_\_\_\_) \_\_\_\_\_  
 Yes, messages can be left at this number.  Yes, messages can be left at this number.

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN \_\_\_\_-\_\_\_\_-\_\_\_\_ Age \_\_\_\_\_ Sex:  M  F

Email Address \_\_\_\_\_@\_\_\_\_\_

Emergency Contact \_\_\_\_\_  
*Name Phone Relationship*

**INSURANCE POLICY HOLDER (IF DIFFERENT FROM PATIENT) PRINT NAME AS IT APPEARS ON THE INSURANCE CARD.**

Name \_\_\_\_\_  
*Last First MI*

Address \_\_\_\_\_  
*Street Apt # City State Zip*

Home Phone (\_\_\_\_) \_\_\_\_\_ Alternate Phone (\_\_\_\_) \_\_\_\_\_

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN \_\_\_\_-\_\_\_\_-\_\_\_\_ Relationship to Patient \_\_\_\_\_ Sex:  M  F

**PRIMARY INSURANCE INFORMATION**

Insurance Company \_\_\_\_\_ Benefit Phone \_\_\_\_\_

Subscriber ID # \_\_\_\_\_ Group # \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION (IF APPLICABLE)**

Insurance Company \_\_\_\_\_ Benefit Phone \_\_\_\_\_

Subscriber ID # \_\_\_\_\_ Group # \_\_\_\_\_

**I have read all of the above information and have completed it to the best of my knowledge. I will notify you of any changes in my health status or demographic information. I hereby authorize Urgent and Family Care at Avery Ranch to furnish information to insurance carriers concerning my medical status. I understand that I am responsible for any amount not covered by my insurance.**

Signature of Patient/Guardian \_\_\_\_\_

Date \_\_\_\_\_

For Office Use Only

Rm \_\_\_\_\_  
Checkout?  
 Yes  
 No

IN  
 OUT  
 PVP  
 W/C

Patient is:  
 New Pt  
 F/U  
 Est Pt



For MA Use Only

Height \_\_\_\_\_ Weight \_\_\_\_\_  
Temp \_\_\_\_\_ Pulse \_\_\_\_\_  
BP \_\_\_\_\_/\_\_\_\_ LMP \_\_\_\_\_  
Resp \_\_\_\_\_ Pul Ox \_\_\_\_\_

DEMOGRAPHIC INFORMATION

Name \_\_\_\_\_  
*Last First MI*

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN \_\_\_\_-\_\_\_\_-\_\_\_\_

Male  Female, if you are female:  
Are you pregnant?  No  Yes  
Breast feeding?  No  Yes

REASON FOR VISIT TODAY

Reason for visit today \_\_\_\_\_

This is a **follow up visit**: condition is:  Better  Worse  Same

Please explain: \_\_\_\_\_

Symptoms Present for: \_\_\_\_\_  days  weeks  months

Is this a **work comp** injury/illness?  No  Yes

SOCIAL HISTORY

Marital Status: \_\_\_\_\_

Occupation: \_\_\_\_\_

Smoke?  No  Yes; \_\_\_\_\_ packs/day  
Alcohol?  No  Yes; \_\_\_\_\_ drinks/week

ALLERGIES

Medication Allergies  No known drug allergies  
Non-Drug Allergies  No known allergies

CURRENT MEDICATIONS

PLEASE LIST PRIOR SURGERIES & MEDICAL PROBLEMS

PAST MEDICAL HISTORY/FAMILY HISTORY

	Yourself	Blood Relative
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer: _____	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Hayfever, allergies, hives	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
None of the above	<input type="checkbox"/>	<input type="checkbox"/>

PHYSICIAN INFORMATION

Do you want information sent to your physician regarding your treatment today?  No  Yes

If yes, \_\_\_\_\_  
*Name Phone Number*

TREATMENT CONSENT AND AUTHORIZATION

I understand that the physicians at Urgent and Family Care are not prepared to treat chronic health needs. If I have any chronic health conditions Urgent and Family Care can treat this condition initially but it is important for me to establish care with a family practice physician. As a courtesy, Urgent and Family Care can provide a list of area practitioners at my request.

I have read the above information and consent that it is correct to the best of my knowledge. I authorize Urgent and Family Care at Avery Ranch, LLP and its healthcare providers to render necessary treatment for my condition.

Signature of Patient/Guardian \_\_\_\_\_

Date \_\_\_\_\_

Call back necessary in \_\_\_\_\_ days or \_\_\_\_\_ weeks.

For Physician  
Use Only

This form has been reviewed by the treating physician.  
Physician Signature \_\_\_\_\_



**Release of Information**

Patient Name: \_\_\_\_\_  
Last First MI Date of Birth

By signing this form, I authorize Urgent and Family Care, LLP and its staff to use and disclose the protected health information described below, to the individuals named. These individuals may also pick up prescriptions, samples, medical records and other health related items on my behalf. **If patient is a minor, please list parents' names below.**

**What level of information can we release?**

- All information including specific medications and dosages, lab results and information related to sensitive issues such as sexually transmitted diseases (including but not limited to AIDS and Hepatitis C).
- All information except \_\_\_\_\_
- No information whatsoever

**To whom can we release information (please list names):**

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- No one except the patient can obtain information.

**I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the person or entity releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I authorize the release of any medical or other information to my insurance companies necessary to process insurance claims.**

**Financial Agreement**

Payment is due in full at the time of service. Acceptable methods of payment are cash, personal check, Visa, MasterCard, Discover, or American Express. I authorize use of outside check verification agencies utilized by Urgent and Family Care. There will be a \$25.00 fee on any returned checks.

I understand that my insurance policy is a contract between myself and my insurance company; Urgent and Family Care is not involved. If I have questions or concerns regarding my coverage for office visits, procedures, lab work, medications, or particular conditions I am responsible for obtaining this information. I agree to pay in full for all services considered "non-covered" services per my insurance policy if I choose to have the service provided.

If my insurance company does not pay in consideration of the services provided, or I do not have insurance, I agree to pay all charges of Urgent and Family Care. Should the account become delinquent, I understand that my account will be referred on to a collection agency and I might be asked to seek treatment elsewhere until my account is reconciled.

**HIPAA**

Urgent and Family Care at Avery Ranch upholds the standards of the HIPAA laws. As a patient, we want you to know:

- We respect the privacy of your personal medical records and will do all we can to secure and protect that privacy.
- When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.
- You may refuse to consent to the use or disclosure of your personal health information, but *this must be in writing*.
- Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). This information is critical in making appropriate medical decisions.

If you have any questions regarding this consent, please speak with one of the staff of Urgent and Family Care at Avery Ranch.

**I have read and understand the above information. My signature here indicates compliance with the above policies.**

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date