New Patient Registration Information

Please print and complete ALL sections

Arrival Time: _____ **Pharmacy:** _____

Today's Complaint:

_____

_____

Patient's Personal Information

Marital Status □ Single □ Married □ Divorced □ Widowed **Sex:** □ Male □ Female

Name: _____ _____ _____
Last Name *First Name* *M.I.*

Date of Birth: _____/_____/_____ **Social Security #:** _____ - _____ - _____

Home Phone: (_____) _____ - _____ **Cell:** (_____) _____ - _____

Address: _____ **Apt.#:** _____ **City:** _____ **State:** _____ **Zip:** _____

Email Address: _____ **Primary Care Physician:** _____

Patient's/Responsible Party Information

Primary Insurance Name: _____

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Name of Insured: _____ **Date of Birth:** _____/_____/_____

Relationship to Insured: □ Self □ Spouse □ Child □ Other

Policy #: _____ **Group #:** _____

Secondary Insurance Name: _____

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Name of Insured: _____ **Date of Birth:** _____/_____/_____

Relationship to Insured: □ Self □ Spouse □ Child □ Other

Policy #: _____ **Group #:** _____

Emergency Contact

Name: _____ **Relationship:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: (_____) _____ - _____ **Cell Phone:** (_____) _____ - _____

Assignment of Benefits – Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Family First Urgent Care and any assigning physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by my insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize the healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Your Signature: _____ **Date:**_____

Allergies

MEDICATIONS ☐ **No Known Drug Allergies**

_____
_____
_____

FOODS ☐ **No Known Food Allergies**

_____
_____
_____

Current Medications

☐ **No Current Medications**

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Immunizations

Please indicate whether immunizations are up-to-date. If unknown, state unknown.

☐ **Immunizations are up-to-date** ☐ **Unknown if immunizations are up-to-date**

Past Medical History (check all that apply)

☐ Headaches
☐ High Blood Pressure
☐ Stroke
☐ High Cholesterol
☐ Chest Pain/Angina
☐ Congestive Heart Failure
☐ Heart Palpitations
☐ Heart Murmur
☐ Heart Attack
☐ Congenital Heart Disease
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Allergies/Hay Fever
☐ Asthma
☐ Emphysema
☐ Sexual Dysfunction
☐ Venereal Disease
☐ Positive TB Screening
☐ Glaucoma
☐ Liver Disease
☐ Ulcer
☐ Gout
☐ Bowel Irregularity
☐ Shortness of Breath
☐ Diabetes
☐ Anemia
☐ Previous Blood Transfusion
☐ Aids/HIV
☐ Hearing Loss
☐ Menstrual Dysfunction
☐ Epilepsy
☐ Depression
☐ Arthritis
☐ Dizziness/Fainting
☐ Prostate Disease
☐ Thyroid Disease
☐ Bladder Dysfunction
☐ Cancer: Type _____
☐ Other: _____

Habits (check all that apply)

□Smoke (if yes): Packs daily _____ Stopped when: _____ □ Other tobacco products _____

□Recreational/street drug use (specify) _____

□Alcohol (if yes) Type _____

Family History

Has any blood relative had any of the following? Check all that apply and list which family member.

□ Bleeding Tendency or Clotting Problems _____ □ Diabetes _____ □ Heart Disease_____

□ Mental Health Disorder _____ □ Epilepsy _____ □ High Blood Pressure _____

□ Cancer (type) _____ □ Other: _____

□ Tuberculosis _____

Men Only

Date of last rectal exam: _____

Date of last PSA: _____

Sexually active: □ No □ Yes

Practice safe sex: □ No □ Yes

Women Only

Last menstrual period: _____

Age of onset: _____ □ Regular □ Irregular

Flow: □ Heavy □ Moderate □ Light

Days of flow: _____

Length of cycle: _____

Last pap smear: _____

Last mammogram: _____

Monthly self-breast exam: □ Yes □ No

Flushing/Menopause: □ Yes □ No

Sexually active: □ Yes □ No

Practice safe sex: □ Yes □ No

Pain/Cramps with menses: □ Yes □ No

Pregnant: □ Yes □ No

Number of pregnancies: _____

Number of live births: _____

Number of miscarriages: _____

Birth control method: _____

Name of birth control if using: _____

Signature_____

Date_____ **Relationship** (if other than self)_____

Patient Consent Form

I hereby give my consent for **Family First Urgent Care** to use and disclose **Protected Health Information (PHI)** about me to carry out **treatment, payment and healthcare operations (TPO).** (The Family First Urgent Care Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the **Notice of Privacy Practices** prior to my signing this consent. **Family First Urgent Care** may call my home or other alternative location to leave a message on voicemail or in person about any items that may assist the practice in carrying out TPO, such as appointment reminder and patient statements as long as they are marked personal and confidential.

I have the right to request that Family First Urgent Care restrict how it uses or discloses my **PHI** to carry out my **TPO.**

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign the consent, or late revoke it, Family First Urgent Care may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Print Name of Legal Guardian

Acknowledgment of Receipt of Privacy Notice

I understand a copy of the Notice of Privacy Practices of Family First Urgent Care is posted in the waiting room for me to review.

I understand that if any changes are made to this Notice of Privacy Practices, a revised copy of the notice will be posted in the office of Family First Urgent Care.

I also understand that if I wish to receive additional copies of the Notice of Privacy Practices in the future or if I have any questions with regard to the Notice of Privacy Practices, I may contact:

Family First Urgent Care
2525 Cornwell Drive
Yukon, OK 73099

_____ _____

Print Name of Patient Patient DOB

_____ _____

Signature of Patient or Legal Guardian Date

_____

Printed name of Legal Guardian

Guarantee of Payment for Services & Assignment of Benefits

It is the policy of Family First Urgent Care that you must pay for services rendered.

As a courtesy, Family First Urgent Care will file primary insurance claims only, unless the primary insurance is Medicare. If this applies to you we will file secondary insurance.

In the event that any of the above-named companies or individuals fail to make prompt payment, I hereby give my personal guarantee of payment for all charges herein occurred. If this account is placed with an attorney and/or collection agency for collection, the undersigned parties agree to pay all reasonable attorney fees and costs of collection.

I hereby authorize insurance benefits to be paid directly to Family First Urgent Care, and I am financially responsible for non-covered services. I also authorize Family First Urgent Care to release any information in the processing of this claim.

I hereby attest that I have read fully and understand fully the statements, guarantee of payment an assignment of benefits outlined above.

PLEASE NOTE:

OUR OFFICE MUST HAVE A COPY OF YOUR CURRENT INSURANCE CARD OR YOU WILL BE EXPECTED TO PAY IN FULL AT THE TIME OF SERVICE. ENROLLMENT FORMS WILL NOT BE ACCEPTED. WE WILL NOT BE ABLE TO CALL FOR INSURANCE VERIFICATION AT THE TIME OF YOUR VISIT.

Insurance and Coverage and Referral Waiver

I understand that my eligibility for coverage has not been verified at the time of my appointment, but I want to receive medical services from Family First Urgent Care.

I am aware that when the insurance is finally verified, there is a disclaimer, which states that they do not guarantee payment, even though I may be eligible for benefits at the time of service. I further understand that it is not the responsibility of Family First Urgent Care to know what my plan benefits are. If it is determined that I am not eligible for coverage or that the medical services are not covered, I understand that I will be responsible for payment for all services provided.

Patient Signature: _____ Date:_____

Your health is important to us. In order to provide you with the best possible care, we occasionally send convenient text & email messages to our patients about their health care and the products and services we offer.

Please list the mobile device(s) associated with your patient files at Family First Urgent Care below:

Cell Number: _____

Email Address: _____

You are consenting to receive text and email messages for appointment reminders and information about your health care treatments.

Signature: _____ Date: _____