HOW DID YOU HEAR ABOUT US: □ Insurance □ School □ Internet □ Word of Mouth □ Drive By

PATIENT INFORMATION

Date of Birth / / Age Address

Last Name Apt Preferred Phone ( ) —

First Name City Alternate Phone ( ) —

Middle Initial Sex □ M □ F State ZIP Email

Social Security # — —

PRIMARY CARE PHYSICIAN

Name

Phone ( ) —

IN CASE OF EMERGENCY

Name

Phone ( ) —

Relation

EMPLOYER

Name

Phone ( ) —

PARENT/RESPONSIBLE PARTY INFORMATION (if minor)

Date of Birth / / Age Address

Last Name Apt Preferred Phone ( ) —

First Name City Alternate Phone ( ) —

Middle Initial Sex □ M □ F State ZIP Email

Social Security # — — Relation to Patient □ Parent □ Guardian □ Spouse □ Employer

PRIMARY INSURANCE

Insurance Name _____ IS ADDRESS SAME AS PATIENT OR GUARANTOR? ❑ YES ❑ NO

Member ID _____

Group # _____ Address _____

Date of Birth ___/___/___ Age _____ Apt _____ Preferred Phone _____

Last Name _____ City _____ Alternate Phone _____

First Name _____ State _____ Zip _____ Email _____

Middle Initial _____ Sex ❑ M ❑ F

Social Security # _____ Relation to Patient: ❑ Parent ❑ Guardian ❑ Spouse ❑ Employer

AUTHORIZATION AND RELEASE

By signing this consent form I acknowledge that I have read, understand, voluntarily consent to and authorize the following:
Authorization of Treatment: The administration and cost of all medical and surgical procedures, x-ray, and medication for myself and for my dependents.

Guarantee of Payment:

_____**Initial SELF PAY** – I elect to pay for all services rendered in full today. I understand that my insurance will **NOT** be billed by 45 Urgent Care.

_____**Initial INSURANCE** – Assignment of Benefits: I authorize payment directly to 45 Urgent Care for all benefits otherwise payable to me. I also acknowledge that 45 Urgent Care will submit my bill to my insurance carrier as a courtesy; however, I am ultimately responsible for all charges incurred. I agree that I will pay my estimated balance based on the best available information of my current policy and 45 Urgent Care current contract with my insurance carrier. I understand this is only an estimate and after my visit is processed with my insurance company, I will be billed for any outstanding balance and/or refunded for any credit due to or by me. While 45 Urgent Care makes every effort to verify my correct insurance information prior to leaving, I understand 45 Urgent Care cannot guarantee the accuracy of my bill until it has been fully processed by my insurance carrier and that I am ultimately responsible for all charges incurred.

If you have an outstanding balance on your account that is not paid within 90 days we will turn your account over for collections. I understand and agree that all collection agency fees and/or attorney fees associated with the collection process will be my responsibility. **There will be a 30% charge for any account over $100 and 50% charge for any account under $100.**

LAB WORK POLICY

Any Labs not conducted in clinic are sent out in accordance with your insurance carrier and/or preference. Be advised that the fees associated with these tests are ***in addition*** to your current charges with 45 Urgent Care and will be billed separately to your insurance carrier as a courtesy by the lab; however, you are ultimately responsible for these charges and may receive a bill directly from the lab. These charges are NOT associated with 45 Urgent Care. Should you have questions in regard to the billing of these particular lab charges, you will need to contact the lab company directly.

By voluntarily signing this form I acknowledge that I have provided 45 Urgent Care with all current insurance information, read and understand ALL content within AND agree to the release of records, responsibility of payment, treatment, procedures and lab work policy as stated.

Patient/Responsible Party Signature_____**Date** _____

FAMILY HISTORY

Please mark if your mother or father has had any of these symptoms in the past:

Mother	Father		Mother	Father		Mother	Father	
❑	❑	Heart Disease	❑	❑	serious injury	❑	❑	scarlet fever
❑	❑	anemia	❑	❑	epilepsy	❑	❑	nervousness
❑	❑	arthritis	❑	❑	Measles	❑	❑	numbness
❑	❑	asthma	❑	❑	headaches	❑	❑	polio
❑	❑	heart trouble	❑	❑	poor circulation	❑	❑	venereal disease
❑	❑	bladder trouble	❑	❑	reproductive disorders	❑	❑	hepatitis
❑	❑	high blood pressure	❑	❑	rheumatic fever	❑	❑	Stroke
❑	❑	cancer	❑	❑	HIV/ARC	❑	❑	rheumatism
❑	❑	chest pain	❑	❑	kidney disorder			
❑	❑	concussion	❑	❑	bowel control loss			
❑	❑	convulsions	❑	❑	menstrual cramps			
❑	❑	diabetes	❑	❑	multiple sclerosis			
❑	❑	muscular dystrophy	❑	❑	tuberculosis			

Patient Name: _____

DOB: _____/_____/_____

PATIENT HISTORY

Please mark an (x) by the conditions you may have or have had in the past:

_____Heart Disease	_____Seizures	_____**None**
_____High Blood Pressure	_____Mental Health Problems	
_____High Cholesterol	_____Thyroid Disease	
_____Diabetes	_____Cancer (past or present)	
_____Stroke	Other_____	

PLEASE LIST CURRENT MEDICATIONS (include non-prescription products) _____None

1)_____ 2) _____ 3) _____

4) _____ 5) _____ 6) _____

7) _____ 8) _____

PLEASE LIST ANY MEDICATIONS THAT YOU ARE ALLERGIC TO _____**None**

1) _____ 2) _____ 3) _____

4) _____ 5) _____ 6) _____

OTHER ALLERGIES _____**None**

1) _____ 2) _____ 3) _____

MAJOR SURGERIES _____None

1)_____ APPROX DATE _____

2)_____ APPROX DATE _____

3)_____ APPROX DATE _____

PERSONAL HABITS

1) Do you drink caffeinated beverages (coffee, tea, soda)?_____Daily intake? _____

2) Do you drink alcoholic beverages?_____If yes,_____drinks/□ day, □ week, □ month

3) Do you smoke or chew tobacco?_____If yes,_____/day,_____years of use

If No, any prior nicotine use?_____years