

Patient Registration Form

Please Print Clearly

Patient Name: Last _____ First _____ Middle initial _____

Date of Birth ____/____/____ Social Security# ____-____-____ Gender: M/F

Mailing Address _____ Apt/lot/PO Box # _____

City _____ State _____ Zip Code _____ \

Home Phone #(____)____-____ Other #(____)____-____

Employer _____ Write in N/A if unemployed

Occupation _____

Marital Status: (Circle One) Single Married Divorced Widowed

Family Doctor _____ City _____

**How did you hear about us? (Circle One)* Newspaper Internet Phonebook Referral _____

Insurance Carrier or Parent (Complete only if different than patient)

Last Name: _____ First _____ Middle Initial _____

Gender: M/F Date of Birth ____-____-____ Social Security # ____-____-____

Relationship to Patient _____ Address _____

Phone #(____)____-____ Other #(____)____-____

Employer _____

Emergency Contact:

Full Name: _____ Relationship _____

Address _____ Phone #(____)____-____

Notice of Payment Responsibility

I, the undersigned, a patient of Surprise Family Urgent Care, do hereby authorize physicians and staff of Surprise Family Urgent Care to administer treatment as is necessary. I understand as a courtesy Surprise Family Urgent Care will prepare insurance forms and bill my insurance company directly. I hereby request assignment of payment of all insurance benefits to Surprise Family Urgent Care. I am ultimately responsible for all services rendered, unless otherwise provided by law.

Surprise Family Urgent Care participates with many insurance companies. However, if you have a plan in which we are not a provider, you are ultimately responsible for any charges incurred from your visit. ***It is your responsibility to know the limitations of your coverage and what your benefits include.***

You are financially responsible for all charges incurred for your treatment unless we can verify insurance benefits and expect to receive payment from a valid insurance plan. Your policy determines the extent to which you will be responsible for deductibles, co-payments, co-insurance, and non-covered services. Surprise Family Urgent care is not responsible for incorrect information given by your insurance company or failure of your employer to provide accurate information to your insurer about your employment status. Payments to Surprise Family Urgent care are subject to audit and may require refunds that make you responsible for the charges.

The coverage available to you depends upon your employment status and the choices you make within the plans that are offered to you by your employer and your current coverage status.

I have read and understand the above policies, and agree to accept full financial responsibility as described. I authorize payment to Surprise Family Urgent Care of insurance benefits for claims submitted on my behalf. I authorize Surprise Family Urgent Care to release any medical information necessary for claims payments.

Patient /Parent or Guardian Signature _____ Date _____

Printed Name _____

Privacy Practices Acknowledgement

I consent to the use or disclosure of my protected health information by Surprise Family Urgent Care for the purpose of my diagnosis, treatment, payment, or to conduct health care operations.

I understand the following:

>Diagnosis or treatment of me by Surprise Family Urgent Care may be conditioned upon my consent as evidenced by my signature on this consent.

>I have the right to request a restriction on the uses of my protected health information; the physician's practice may not agree with the restrictions. However, if they do agree, the restriction is binding.

>I have the right to revoke this Consent, in writing, at any time; all future disclosures will subsequently cease. Any disclosures previously made from my prior consent, will not be affected by this revocation.

>Prior to signing this consent, I have the right to review Surprise family Urgent Care's Notice of Privacy Practices, which have been provided to me.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

Surprise Family Urgent Care has a Notice of Privacy Practices. The Notice of Privacy Practices describes how we may use and disclose protected health information about you. The Notice of Privacy Practices also describes patient rights under the law.

At any time, Surprise Family Urgent Care may change the privacy practices as described in the Notice of Privacy Practices. I may contact the office to receive a revised copy.

This document is provided in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This Consent was signed by: _____
Printed Name - Patient or Representative

_____/_____/_____
Signature Date

Relationship to Patient
(If other than patient): _____

Witness: _____
Printed Name - Practice Representative

_____/_____/_____
Signature Date

CONFIDENTIAL MEDICAL HISTORY FORM

Name _____ Birthdate _____ Date _____

Do you: Smoke? Yes / No Packs per day _____ # Years smoked _____

Drink Alcohol? Yes / No Drinks per day _____ Drink cola/coffee? Yes / No How much per day? _____

List the medications you are now taking:

List any allergies you have to drugs, food or other items:

What is the reason for your visit today? _____

WOMEN ONLY:

Age when menstrual periods began _____ Are your periods regular? _____

How Often? _____ How many days do your periods last? _____ How many times have you been pregnant? _____

How many children born alive? _____

Primary Care Physician: Name: _____

Phone: (____) _____ - _____

List any recent major Operations/Surgeries:

Operation Performed	Year	Hospital	Doctor
_____	_____	_____	_____
_____	_____	_____	_____

List all times you have been admitted to a hospital overnight (except for childbirth)

Reason Hospitalized	Year	Hospital	Doctor
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY HISTORY

Please check if any relative (parents, siblings, grandparents, children) have had any of the conditions listed below:

High blood pressure: _____	Kidney Disease: _____	Asthma: _____
Stroke: _____	Bleeding Tendencies: _____	Tuberculosis: _____
Cancer: _____	Seizures: _____	Colitis: _____
Emphysema: _____	Heart Disease: _____	Anemia: _____
Ulcers: _____	Sugar Diabetes: _____	Gout: _____
Mental Illness: _____	Other Serious Illness: _____	

Personal Medical History: Have you had any of the following illnesses: (Please Circle)

- Diabetes Hives Allergies Eczema Venereal Disease Mono Seizures
- Rheumatic Fever Hepatitis Ear Infections Asthma Heart Murmur Glaucoma
- High Blood Pressure Cancer Low Blood Pressure Tuberculosis Heart Attack Ulcers Kidney Stones
- Bladder or Kidney Infection

Other serious illnesses: (Please Explain):

Patient Signature

Date