**Patient Central**
Urgent Care ▪ Primary Care ▪ Heart Care

# PATIENT REGISTRATION INFORMATION

PLEASE PRINT AND COMPLETE ALL SECTIONS OF THIS FORM

LAST NAME___________________ FIRST NAME___________________ INITIAL _______

DATE OF BIRTH ___________________ SEX ❑ M ❑ F SOCIAL SECURITY ___________________

MARITAL STATUS ❑ S ❑ M ❑ W ❑ D ❑ Other___________

ADDRESS ___________________ CITY___________________ STATE________ ZIP ___________

HOME PHONE ___________________ CELL ___________________ EMAIL ADDRESS ___________________

SPOUSE NAME ___________________

RACE ❑ White ❑ Black ❑ Asian ❑ Native Hawaiian/Pacific Islander ❑ American Indian/Alaskan Native ❑ Hispanic ❑ Other

ETHNICITY ❑ Hispanic/Latino ❑ Non-Hispanic/Latino ❑ Unreported/Refused

LANGUAGE ❑ English ❑ Spanish ❑ French ❑ Arabic ❑ Chinese ❑ Sign Language

EMPLOYER ___________________ WORK PHONE ___________________

***Responsible Party Information*** *(for patients under 18 and other dependent patients)*

**Name:**___________________ Relationship to patient:___________________
Last First Middle Initial

Social Sec. #:___________________

Address:___________________ City:___________________ State:________ Zip:___________

**DOB:**___________________ **Sex:** ❑F ❑M Phone:___________________ ❑Home ❑Cell ❑Other
MM/DD/YYYY

***Emergency Contact***

Name:___________________ Phone:___________________ Relationship to patient:___________________

***Patient's Insurance Information***

Primary Policy:___________________

Policy Holder:___________________

Date of Birth:___________________

Relationship to Patient:___________________

Secondary Policy:___________________

Policy Holder: ___________________

Date of Birth: ___________________

Relationship to Patient: ___________________

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# Patient Registration Form (Continued)

## *Financial Agreement*

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Patient Central. I authorize this healthcare provider to release any information necessary to ensure payment by my insurance company. I understand I am financially responsible for all charges not covered by insurance, including patient co-pay, deductible, non-covered services or vaccinations. Charges for paperwork are not covered by insurance, and will be charged a $30 fee. **I understand that my account may be turned over to collections for failure to make payments within 90 days upon receiving my statement.**

Signature of Patient or Legal Guardian ____________________ Date ____________

## *Acknowledgment of Notice of Privacy Practices*

The notice of Privacy Practices was posted in a clear and prominent location where I was able to read the Notice of Privacy Practices. A copy is available to you upon request.

Signature of Patient or Legal Guardian ____________________ Date ____________

## *Notice of Narcotic Policy*

I understand that Patient Central does not prescribe narcotic medications. In the event I should need this type of medication, I understand I will be referred to a specialist or pain management clinic. Patient Central does not prescribe long term pain medications. I fully accept and will comply with this policy of Patient Central.

Signature of Patient or Legal Guardian ____________________ Date ____________

## *Missed Appointments / Same Day Cancellation Policy*

I also acknowledge I am responsible for payment of the fees listed below relating to missed appointments and same-day cancellations.

1st – No Charge
2nd - $25
3rd - $100, also may be subject to immediate discharge from our office.

By signing below, I agree to the above communication preferences, privacy practices, as well as assignment of benefits.

Signature of Patient or Legal Guardian ____________________ Date ____________

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# Urgent Care

Patient Name: ______________________ DOB: ____________ Date: ____________
MM/DD/YYYY

**Reason for being seen today:** ______________________

Have you had any recent international travel? ❑ Yes ❑ No

Is this a follow up visit? ❑ Yes ❑ No

Do you need medication refills? ❑ Yes ❑ No

## Allergies:

Are you allergic to any medications? ❑ Yes ❑ No
If Yes, please list all.

Do you have any other allergies? ❑ Yes ❑ No
If Yes, please list all.

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## Medications:

Are you taking any medications, prescription or over the counter, right now? ❑ Yes ❑ No
If Yes, please list all medications.

| Medication Name | Strength | Quantity taken at one time | Times per day taken |
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Please list any other medications on the back of this form.

## Social History:

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| Do you use tobacco? | ❑ Yes, everyday | ❑ Yes, on occasion | ❑ No, former user | ❑ No, never |
| Do you drink alcohol? | ❑ Yes, everyday | ❑ Yes, socially | ❑ No, former user | ❑ No, never |
| Do you use illegal drugs? | ❑ Yes, everyday | ❑ Yes, socially | ❑ No, former user | ❑ No, never |
| Are you currently employed? | ❑ Yes, full time | ❑ Yes, part time | ❑ No, retired | ❑ No, other |

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Patient Name:______________________________ DOB:__________ (MM/DD/YYYY) Date:__________

**Reason for being seen today:** ______________________________

Have you had any recent international travel? ❑ Yes ❑ No

Is this a follow up visit? ❑ Yes ❑ No

Do you need medication refills? ❑ Yes ❑ No

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| Do you drink alcohol? | ❑ Yes, everyday | ❑ Yes, socially | ❑ No, former user | ❑ No, never |
| Do you use illegal drugs? | ❑ Yes, everyday | ❑ Yes, socially | ❑ No, former user | ❑ No, never |
| Are you currently employed? | ❑ Yes, full time | ❑ Yes, part time | ❑ No, retired | ❑ No, other |

## Family History:

Does any of your immediate blood relatives (grandparents, parents, siblings) have any of the following conditions?

| Condition | Yes | No | Relative | Condition | Yes | No | Relative |
|---|---|---|---|---|---|---|---|
| Diabetes | | | | Osteoarthritis | | | |
| High Blood Pressure | | | | Rheumatoid Arthritis | | | |
| Heart Disease | | | | Heart Attack/ Murmurs | | | |
| Cancer | | | | Thyroid Disease | | | |
| Type | | | | High Cholesterol | | | |
| Kidney Disease | | | | Liver Disease | | | |
| Dementia | | | | Stroke | | | |

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## Protected Health Information Patient Preferences

Please help us accommodate your wishes regarding how we communicate with you about your health care by completing and signing this form.

❑ Yes ❑ No May we use your first name, last name, or both to identify you in the waiting room? If not, how would you prefer to be identified?

________________________________________

❑ Yes ❑ No May we leave a message on your answering machine or voicemail reminding you of an appointment, or requesting that you call our office? If not, is there an alternate method of contacting you by phone?

❑ Portal ❑ Cell ❑ Other

________________________________________

❑ Yes ❑ No May we leave information regarding an upcoming appointment or a request for you to call us with another individual in your household?

❑ Yes ❑ No May we send written correspondence in a sealed envelope to your home address? If not, is there an alternative address where we may send confidential communications to?

________________________________________

❑ Yes ❑ No Is there another person with whom you give permission for us to speak with about your health care? If yes, please list name(s) and relationship.

________________________________________

________________________________________

________________________________________

Please list any physicians you would like copies of office notes and test results sent to.

________________________________________

________________________________________

________________________________________

________________________________________

________________________________ ________________

Signature of Patient or Legal Guardian Date

**Thank you for choosing Patient Central.**
**We look forward to caring for you!**

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# Are You At Risk of HEART ATTACK?

Patient Name: ______________________________

Date of Birth: ______________________ Today's Date: ______________________

## Have you recently experienced any of the following symptoms?

- ❑ Chest Pain / Pressure / Aching
- ❑ Neck or Jaw Tightness
- ❑ Heart Racing or Skip Beats
- ❑ Dizziness
- ❑ Leg Heaviness or Cramping
- ❑ Persistent Sores on Legs
- ❑ Heart Burn
- ❑ Shortness of Breath
- ❑ Unusual Sweating
- ❑ Loss of Consciousness
- ❑ Leg Swelling
- ❑ Unusual Fatigue/Weakness

## Do you have any of the following conditions?

- ❑ High Blood Pressure
- ❑ Diabetes
- ❑ Family History of Heart Disease
- ❑ Heart Murmur or Heart Valve Problem
- ❑ Carotid Artery Disease
- ❑ Known Heart Disease
- ❑ High Cholesterol
- ❑ Smoking History
- ❑ PAD (Peripheral Arterial Disease)
- ❑ Varicose Veins
- ❑ Obesity
- ❑ Stroke History

# Prevent Heart Disease!

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