REGISTRATION FORM

Today's date:	Primary Care Provider name (Last, First, Middle initial):	Primary Care Provider phone:
Reason for today's visit:		

IS VISIT FOR WORK-RELATED ILLNESS / INJURY? ☐ Yes ☐ No **IS PATIENT A SELF-PAY (CASH) PATIENT?** ☐ Yes ☐ No

Chose clinic because/referred by (please choose): ☐ Friend ☐ TV ☐ Radio ☐ Newspaper/Advertisement ☐ Doctor ☐ Other

PATIENT INFORMATION

Please provide valid photo identification to the receptionist. If patient is a minor, provide identification of financially responsible person.

Last name:	First name, Middle initial:	Birth date:

Mailing address:	Apt:	City:	State:	Zip:

Social security no:	Home phone:	Cell/Other phone:

Email address:	Employer name:	Employer phone:

Is patient a minor? ☐ Yes ☐ No	Sex: ☐ Male ☐ Female ☐ Other	Marital status: ☐ Married ☐ Divorced ☐ Widowed ☐ Single
Race: ☐ Asian ☐ African American ☐ Caucasian ☐ Hispanic ☐ Other ☐ Decline to report	Ethnicity: ☐ Hispanic ☐ Not Hispanic/Latino ☐ Decline to report	Language: ☐ English ☐ Spanish ☐ Creole ☐ Russian ☐ Other

FINANCIALLY RESPONSIBLE PERSON / GUARANTOR

If same as patient write "SELF" in Responsible person Last name box and skip to Insurance Information section.

Responsible person Last name:	Responsible person First name, Middle initial:	Birth date:

Mailing address:	Apt:	City:	State:	Zip:

Social security no:	Home phone:	Cell/Other phone:

Email address:	Employer name:	Employer phone:

INSURANCE INFORMATION

Please give your insurance card(s) to the receptionist. If not-insured write "SELF-PAY" in Primary name box and skip to Emergency Contact section.

PRIMARY insurance name:	Primary insurance policy no:		
Subscriber name:	Birth date:	Social security no:	Group no:

Patient's relationship to primary insurance subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other (specify): ____________________

SECONDARY insurance name (if applicable):	Secondary insurance policy no:		
Subscriber name:	Birth date:	Social security no:	Group no:

Patient's relationship to secondary insurance subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other (specify): ____________________

CONTACT IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):		Relationship to patient:
Home Phone:	Cell phone:	Work phone:

CONSENT

I VOLUNTARILY CONSENT TO RECEIVE MEDICAL HEALTH CARE SERVICE THAT MAY INCLUDE DIAGNOSTIC TESTING, SURGICAL PROCEDURES, EXAMINATIONS, TREATMENTS AND ANY MEDICAL SERVICES THE DOCTOR HAS DEEMED NECESSARY. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS THE BILL TO MY INSURANCE(S) AND HEREBY ASSIGN ALL PAYMENT OF BENEFITS TO ADVANCED URGENT CARE. I ACKNOWLEDGE THAT I AM ULTIMATELY FINANCIALLY RESPONSIBLE FOR PAYMENT OF MEDICAL SERVICES WHETHER OR NOT SUCH SERVICES ARE COVERED BY MY INSURANCE(S).

Signature: ______________________________ Date:____________

MEDICAL HISTORY

DO NOT LEAVE THIS PAGE BLANK

Last Name:	First Name, Middle Initial:	Birth Date:

Height (approximate):	Weight (approximate):	Do you smoke ? ☐ Yes ☐ Never smoked ☐ Previous smoker

Preferred Pharmacy (Name, Address):

DRUG ALLERGIES
Check all that apply.

☐ No known allergies ☐ Penicillin ☐ Aspirin ☐ Sulfa ☐ Iodine ☐ Cipro ☐ Morphine ☐ Amoxicillin ☐ Augmentin

Other drug allergies not listed above: ____

PRESCRIPTION MEDICATIONS
List all prescription medications you are currently taking.

1.	2.
3.	4.
5.	6.
7.	8.
9.	10.

MEDICAL CONDITIONS
Check Yes or No to each of the following:

Yes	No		Yes	No	
		Atrial fibrillation			Emphysema
		Anxiety			Gout
		Arthritis (Osteo, Rheumatoid)			High Blood Pressure
		Asthma			HIV
		Cancer, Type:____________________________			Kidney Stones / Infection
		Cellulitis, Skin Infections, Abscess			Lupus
		Chest Pain			High Cholesterol
		CHF			Heart Attack
		COPD			MRSA
		Coronary Artery Disease			Seizures
		Depression			Stroke
		Diabetes			Liver Disease
		Diverticulitis			Thyroid Disorder

SURGICAL HISTORY
Check all that apply.

☐ No prior surgeries ☐ Tonsillectomy ☐ Gallbladder removal ☐ Caesarian section ☐ Appendectomy ☐ Hysterectomy
☐ Back surgery ☐ Heart stents ☐ Hernia repair ☐ Prostate surgery ☐ Cardiac bypass ☐ Gastric bypass
☐ Shoulder surgery ☐ Knee replacement (LT / RT) ☐ Hip replacement (LT / RT)

Other operations not listed above: ____

CONSENT FOR USE / DISCLOSURE OF HEALTH INFORMATION

Patient's Name: ____

Patient Birth Date: ______________________ Patient SSN or Patient MRN: ______________________

Notice to Patient:

By signing this form, you grant us consent to use and disclose your protected health care information for the purposes of treatment, various activities associated with payment and health care operations. Our **Notice of Privacy Practices** provides more details on our treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.

As stated in our **Notice of Privacy Practices**, we reserve the right to change our privacy practices. If we should do so, we will issue a revised Notice. Since revisions may apply to your health care information, you have a right to receive a *copy* by contacting our Privacy Officer.

You have the right to revoke your Consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this Consent. You should also understand that if you revoke this Consent we may decline to treat you.

You are entitled to a copy of this Consent Form after you have signed it.

I, ______________________________________, have read the contents of this Consent Form and the Notice of Privacy Practices. I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment activities and health care operations.

______________________________________ ______________

Patient's Signature or Signature of Patient's Representative Date

______________________________________ ______________

Printed Name of Patient's Representative Relationship to Patient

Our Privacy Officer can be contacted as follows:

Name of Privacy Officer: **Christina Boros**
Address: **1980 N Roosevelt Blvd, Key West, FL 33040**
Phone: **305-294-0011**
Fax: **305-434-9955**
E-mail: **contact@urgentcarefloridakeys.com**

HIPPA Consent for Use / Disclosure of Health Information

This form does not constitute legal advice and covers only federal, not state, laws.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:
We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

____

Please print your name here

____

Signature

____

Date

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below names(s) of the individual(s) you authorize our office to discuss care with. Your PHI may be disclosed to the individual(s) listed below until you notify us otherwise in writing.

______________________________ ______________________________

______________________________ ______________________________

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy Practices from this patient but it could not be obtained because:

- ◻ The patient refused to sign.
- ◻ Due to an emergency situation is was not possible to obtain an acknowledgement
- ◻ We weren't able to communicate with the patient.
- ◻ Other (*Please provide specific details)*

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______________________________________ ____________________

Employee signature *Date*

HIPPA Acknowledgement of Receipt of Notice of Privacy Practices

This form does not constitute legal advice and covers only federal, not state, laws.