URGENT CARE

ADULT HEALTH HISTORY

Date: _____ Check-in Time: _____

Name: _____ Date of Birth: _____ ☐ Male ☐ Female

Mailing Address: _____
Street City State Zip

Home Ph: (____) _____ Cell Ph: (____)_____ Ok to leave a message? ☐ YES ☐ NO

SS#: _____ Preferred Language: _____

E-mail Address: _____PCP:_____

Insurance Company: _____Same as last visit? ☐ YES ☐ NO

TODAY'S SYMPTOMS: _____

Drug Allergies: _____ Pharmacy/City: _____

If injured, did this occur at work ☐ YES ☐ NO or automobile accident ☐ YES ☐ NO?

PREVIOUS PATIENT: NO CHANGES ☐ (no need to complete form)

HISTORY

_____ Anemia / Blood Problems	_____ Diabetes	_____ Asthma
_____ Arthritis	_____ High Blood Pressure	_____ Lung Problems or COPD
_____ Fibromyalgia	_____ Heart Disease	_____ Liver Problems
_____ Cancer / where _____	_____ High Cholesterol / Triglycerides	_____ Stroke
_____ Stomach / Bowel Problems	_____ Thyroid Problems	_____ Kidney / Bladder Problems
_____ Gallbladder Disease	_____ Hearing Loss	_____ Frequent Headaches
_____ Anxiety	_____ Depression	_____ Seizures
_____ Female Problems	_____ Prostate Problems	_____ Seasonal Allergies

List Others: _____

List Surgeries: _____

_____

Current Medications: NONE _____

_____

Last Tetanus Shot: _____ _____ Unknown

Personal Habits:

Tobacco ☐ **YES** ☐ **NO** # Years: _____ Packs / day? _____ QUIT: _____

Alcohol ☐ **YES** ☐ **NO** How often? _____ QUIT: _____

Other: _____

URGENT CARE

ADULT HEALTH HISTORY

RESPONSIBLE PARTY IF OTHER THAN PATIENT

Last, first name and middle initial this person would be responsible and receive the bills after insurance responded			Date of Birth
Social Security Number	Marital Status	Sex	Home Telephone#
Mailing Address, if different from Patient			Relationship to Guarantor

RELEASE OF INFORMATION-PLEASE LIST ALL PERSONS AUTHORIZED TO OBTAIN MEDICAL/FINANCIAL INFO

Last, first name and middle initial	Relationship:
Last, first name and middle initial	Relationship:
Last, first name and middle initial	Relationship:
Last, first name and middle initial	Relationship:

EMERGENCY CONTACT

Emergency Contact / Relationship	Emergency Contact's Telephone #

CONSENT FOR TREATMENT AND UNDERSTANDING OF FINANCIAL RESPONSIBILITY

The patient agrees to general medical treatment by TexomaCare providers and understands and consents to the review and use of his/her medical records by any TexomaCare provider. All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. However, it is understood and agreed to that the patient is responsible for all fees, regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance.

INSURANCE AUTHORIZATION AND ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize TexomaCare to furnish information concerning my medical condition and treatment thereof to insurance carriers. I also assign insurance benefits paid on my behalf by any and all insurance companies that cover the expenses I incur as the result of any diagnostic services or treatment provided to me by any TexomaCare physician. I further agree that this authorization to release information and assignment of benefits shall remain in effect unless and until it is revoked in writing by me.

I understand that this facility will bill my insurance as a standard office visit and will not be applied towards Urgent Care benefits.

➔ **Signature of patient / legal representative:**

HIPAA – NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you and/or spouse/children may be used and disclosed and how you can get access to this information. I acknowledge that the Texoma Care Notice of Privacy Practices has been provided.

➔ **Signature of patient / legal representative**: