AlphaMed Urgent Care

Full Name:_____ **Date of Birth:**__/__/__

Social Security Number:___-___-___ **Sex:** Male/Female **Race:**_____ **Ethnicity:**_____

Address:_____ **City:**_____ **State:**____ **Zip:**_____

Home Phone:___-___-___ **Cell Phone:**___-___-___ **Preferred Language:**_____

Marital Status: Single / Married / Divorced / Widow

Auto Accident: Yes / No **Workers Comp:** Yes / No

Emergency Contact Name & Phone Number:_____

Primary Care Physician:_____ **Phone Number:**___-___-___

Please make sure to provide ALL of your correct insurance information below. Failure to do so could result in incorrect billing that could leave you with an unpaid balance that you would be responsible for.

Insurance Card Holder/Guarantor Full Name: _____

Date of Birth:__/__/__ **Social Security Number:**___/__/___ **Phone Number:**___-___-___

Address:_____ **City:**_____ **State:**___ **Zip:**_____

Gender: Male / Female **Relationship to Patient:** Parent / Spouse

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Responsible Party: If the patient is a minor (under the age of 18), the parent or guardian bringing the patient will be listed as the Responsible Party.

Responsible Party Full Name:_____

Relationship to Patient:_____ **Sex:** Male / Female

Date of Birth:__/__/__ **Social Security Number:**___-___-___ **Phone Number:**___-___-___

Address:_____ **City:**_____ **State:**___ **Zip:**_____

Responsible Party Signature:_____ **Date:**___/___/___

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Patient Health History Form

Preferred Pharmacy:_____ **Pharmacy Address:**_____

Reason for Visit:_____

Are you fully vaccinated for COVID?: Yes/No
Have you got your booster? Yes / No / Not eligible for booster

Current Medication List:

Medication/ Food Allergies:

Diagnosed Medical History: (please check all that apply)

High Blood Pressure	Stroke	Chronic Back Pain
High Cholesterol	Depression	Heart Arrhythmia
Kidney Stones	Anxiety	Arthritis
Diabetes Type 1	Blood Clots	Congestive Heart Failure
Diabetes Type 2	GERD/Acid Reflux	Glaucoma
COPD	Sleep Apnea	Asthma

Any other diagnosis not listed above:_____

Past Surgeries:

Do you currently use any of the following?

Tobacco: None/Smoke/Chew	**Vape:** Yes / No	**Alcohol:** Yes / No	**Street Drugs:** Yes / No

OFFICE USE ONLY:

Temp:_____ **HR:**_____ **BP:**_____/_____ **RR:**_____/Min **O2:**_____%

Ht:_____ **Wt:**_____ **LMP:**_____

AlphaMed Urgent Care

AUTHORIZATION & AGREEMENT

HIPAA Patient Consent

By signing below, I have read and fully understand the Patient Consent for Use and Disclosure of Protected Health Information, rev. 7/ 2016. I consent and agree to all of its terms and conditions. I understand copies of AlphaMed Urgent Care's full Notice of Privacy Practices are available on request.

Patient Responsibility and Financial Policy Clause

By signing below, I have read and fully understand AlphaMed Urgent Care's Patient Responsibility and Financial Policy. I accept and agree to all of its terms and conditions. Specifically, I understand that I am responsible for any medical treatment and medical equipment not covered by my insurance plan or applied towards my copay, coinsurance, and/or deductible. These services include, but are not limited to: Injections (administration fee & medicine), IV treatments and fluids (initial IV treatment, hydration, medicine, etc.), and durable medical goods (crutches, walking boots, splints, slings, ace wraps, etc.) I understand that balances may be assessed interest and collection fees. I understand that any overpayments may remain as a credit balance on my account, to be applied to future charges.

Consent for Treatment

By signing below, I understand that I have a choice to be seen at AlphaMed Urgent Care versus the Hospital Emergency Department, my primary care, or a specialist. I authorize AlphaMed Urgent Care to provide medical treatment and services to me. I understand I am authorizing The Urgent Care to treat me while I seek care from AlphaMed Urgent Care or until I withdraw my authorization in writing.

Patient/Legal Guardian Signature:_____ **Date:** ____/___/____

I declare the above information is true. I authorize my insurance benefits to be paid to AlphaMed Urgent Care. I understand that I am financially responsible for any charges that may not be covered by my insurance plan. I authorize my medical information to be released to my insurance company/ any of its affiliates for medical purposes.

AlphaMed
Urgent Care

Authorization to Release Healthcare Information (HIPPA Release Form)

Patient's Name:_____

Patient's DOB:____/____/____ **Patient's Phone Number:**_____-_____-_____

Release of Information

I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to the following: **(Please Print full name and Phone number)**

☐**Spouse:**_____

☐**Parent:**_____

☐**Child(ren):**_____

☐**Employer:**_____

☐**Doctor:**_____

☐**Other:**_____

☐**My information is not to be released to anyone.**

This release of information will remain in effect until terminated by me in writing.

Messages (if unable to reach me)

☐ Please leave me a detailed message.

☐ Please leave a message asking me to return your call.

Signature:_____ **Date:**___/___/___