PATIENT REGISTRATION FORM

How did you hear about us? Friend Internet Yelp Magazine Newspaper Facebook

TREASURE COAST Urgent Care

PATIENT INFORMATION

Patient Information — Is this a work related incident? ☐ YES ☐ NO Motor Vehicle Accident? ☐ YES ☐ NO

Last Name:	First Name:	M.I.:	Previous Name (if applicable)
Mailing Address:		Apt #	
City/State/Zip:			
Home Phone:	Cell Phone:	Work Phone:	
Preferred Method of Contact for Reminder Calls and Other Electronically Generated Messages: (Please Select Only One Option) ☐ Voice ☐ Text		If Voice, Please Select Preferred Number: ☐ Home ☐ Cell ☐ Work	
Family Physician or Pediatrician:	Date of Birth:	Sex: ☐ Male ☐ Female	
Marital Status:	Social Security #:		
Employer Name:	Emergency Contact Name:		
Emergency Contact Phone #:	Relationship to Patient:		

Additional Information and Responsible Party

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

Last Name:	First Name:	
Date of Birth:	Social Security #:	Phone:
Address of Person Responsible:		
City/State/Zip:	Relationship to Patient:	

Additional Information **(PLEASE FILL OUT ALL SECTIONS BELOW)**

Email Address:	**Can we leave a message regarding your medical care & test results?** ☐ Yes ☐ No
Race (please select): ☐ White ☐ American Indian or Alaska Native ☐ Asian ☐ Hispanic ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ Other ☐ Decline	**Ethnicity (please select one):** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline
Preferred Language (please select one): ☐ English ☐ Bosnian ☐ Indian (including Hindi & Tamil) ☐ Sign Language ☐ Spanish ☐ Russian ☐ Other	
Preferred Pharmacy Name & Location:	

Insurance Information

Primary Medical Insurance	**Secondary Medical Insurance**
Ins. Co. Name	Ins. Co. Name
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

ALL INSURANCE AND SELF PAY PATIENTS: ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT'S ACCOUNT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIERS PAYMENTS; HOWEVER, IF INSURANCE IS DENIED OR INSURANCE INFORMATION IS NOT RECEIVED AT THE TIMEOF SERVICE THE PATIENT/ GUARDIAN IS RESPONSIBLE FOR ALL APPLICABLE FEES. IT IS CUSTOMARY TO PAY APPLICABLE CO- PAY/CHARGES WHEN SERVICES ARE RENDERED UNLESS OTHER ARRANGEMNETS HAVE BEEN MADE IN ADVANCE WITH OUR OFFICE MANAGER.

If visit is to be submitted to an insurance company, please read and initial the following: I request that payment of authorized Medicare/ or other Insurance Carrier of benefits be made either to me or on my behalf to Treasure Coast Urgent and Family Care for any services furnished to me by that party. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me, to release to the Social Security Administration and CMS or its intermediaries or carriers any information needed for this or a related Medicare/Other Insurance claim. I permit a copy of this authorization to be used in place of the original and request payment of medical Insurance benefits to the party who accepts the assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment (Section 1128B of the Social Security Act and 31 U.S.C3801-3212 provides penalties for withholding this Information)

I have reviewed and understand the above insurance information: _____ **(Initials)**

Signature of Responsible Party: **X** _____ **Date:**

Printed Name of Responsible Party: **X** _____ **Date:**

Health History Form

TREASURE COAST Urgent Care

E-mail: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: Last First Middle | Home Phone: ( ) | Cell Phone: ( )

Address: Mailing address | City: | State: | Zip:

Occupation: | Height: | Weight: | Date of birth: | Sex: M F

SS# or Patient ID: | Emergency Contact: | Relationship: | Phone:

If you are completing this form for another person, what is your relationship to that person?

Your Name | Relationship

Do you have any of the following diseases or problems:

	Yes	No
Active Tuberculosis	☐	☐
Persistent cough greater than a 3 week duration	☐	☐
Cough that produces blood	☐	☐
Been exposed to anyone with tuberculosis	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No
Are you now under the care of a physician?	☐	☐

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

Are you in good health?	☐	☐
Has there been any change in your general health within the past year?	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

SERIOUS ILLNESS OR PROBLEM

	Yes	No
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐

If yes, what was the illness or problem?

_____

CURRENT PRESCRIPTIONS/MEDICATIONS

Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

LIST MEDICATIONS: (Include Dosage & Frequency)

_____

_____

_____

_____

FAMILY HEALTH HISTORY: (please list any known family health issues)

_____

_____

_____

_____

Medical Information

TREASURE COAST Urgent Care

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No
Do you wear contact lenses?	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐
Date: _____ If yes, have you had any complications?_____		
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐
Date Treatment began: _____		

	Yes	No
Do you use controlled substances (drugs)?	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐
If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED		
Do you drink alcoholic beverages?	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____		
If yes, how much do you typically drink In a week? _____		
WOMEN ONLY Are you:		
Pregnant?	☐	☐
Number of weeks: _____		
Taking birth control pills or hormonal replacement?	☐	☐
Nursing?	☐	☐

Allergies - Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No
Local anesthetics_____	☐	☐
Aspirin _____	☐	☐
Penicillin or other antibiotics_____	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐
Sulfa drugs _____	☐	☐
Codeine or other narcotics _____	☐	☐
Metals_____	☐	☐
Latex (rubber) _____	☐	☐
Iodine _____	☐	☐
Hay fever/seasonal _____	☐	☐
Animals_____	☐	☐
Food _____	☐	☐
Other _____	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No
Artificial (prosthetic) heart valve	☐	☐
Previous infective endocarditis	☐	☐
Damaged valves in transplanted heart	☐	☐
Congenital heart disease (CHD)		
Unrepaired, cyanotic CHD	☐	☐
Repaired (completely) in last 6 months	☐	☐
Repaired CHD with residual defects	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No
Cardiovascular disease.	☐	☐
Angina	☐	☐
Arteriosclerosis	☐	☐
Congestive heart failure	☐	☐
Damaged heart valves	☐	☐
Heart attack	☐	☐
Heart murmur	☐	☐
Low blood pressure	☐	☐
High blood pressure	☐	☐
Other congenital heart defects	☐	☐
Mitral valve prolapse	☐	☐
Pacemaker	☐	☐
Rheumatic fever	☐	☐
Rheumatic heart disease	☐	☐
Abnormal bleeding	☐	☐
Anemia	☐	☐
Blood transfusion	☐	☐
If yes, date:_____		
Hemophilia	☐	☐
AIDS or HIV infection	☐	☐
Arthritis	☐	☐
Autoimmune disease	☐	☐
Rheumatoid arthritis	☐	☐
Systemic lupus erythematosus.	☐	☐
Asthma	☐	☐
Bronchitis	☐	☐
Emphysema	☐	☐
Sinus trouble	☐	☐
Tuberculosis	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐
Chest pain upon exertion	☐	☐
Chronic pain	☐	☐
Diabetes Type I or II	☐	☐
Eating disorder	☐	☐
Malnutrition	☐	☐
Gastrointestinal disease	☐	☐
G.E. Reflux/persistent heartburn	☐	☐
Ulcers	☐	☐
Thyroid problems	☐	☐
Stroke	☐	☐
Glaucoma	☐	☐
Hepatitis, jaundice or liver disease	☐	☐
Epilepsy	☐	☐
Fainting spells or seizures	☐	☐
Neurological disorders	☐	☐
If yes, specify:_____		
Sleep disorder	☐	☐
Mental health disorders	☐	☐
Specify:_____		
Recurrent Infections	☐	☐
Type of infection:_____		
Kidney problems	☐	☐
Night sweats	☐	☐
Osteoporosis	☐	☐
Persistent swollen glands in neck	☐	☐
Severe headaches/ migraines	☐	☐
Severe or rapid weight loss	☐	☐
Sexually transmitted disease	☐	☐
Excessive urination	☐	☐

Do you have any disease, condition, or problem not listed above?

Comments:_____

_____

Signature of Patient/Legal Guardian:

Date:

HIPAA Medical Release Form

TREASURE COAST Urgent Care

Health Insurance Portability and Accountability Act – Privacy Form

ACKNOWLEDGEMENT AND NOTICE OF PRIVACY PRACTICES & PERMISSION TO SHARE HEALTH INFORMATION

_____

Patient Name (please print)

I understand that my medical records are protected by federal law and that the information can only be released as per the Health Information Privacy and Portability Act. *(A copy is available upon request at the front desk)*

☐ All Forms ☐ Electronic copy or web-based portal ONLY ☐ Hard Copy ONLY

NOTIFICATION OF FAMILY AND FRIENDS

I hereby authorize **Treasure Coast Urgent Care** to disclose my protected health information to the following individual(s):

Name	Email	Phone/Fax
Name	Email	Phone/Fax

I understand that the above may not be covered by state/federal rules governing privacy of data and may be permitted to further share information provided to them.

NOTIFICATION OF PHYSICIANS

I hereby authorize **Treasure Coast Urgent Care** to disclose my protected health information to the following physician(s):

Physician Name or Practice	Email	Phone/Fax
Physician Name or Practice	Email	Phone/Fax

I understand that the above may not be covered by state/federal rules governing privacy of data and may be permitted to further share information provided to them.

NOTICE OF VOICEMAIL AND MESSAGES

Voice messages may be left on the phone number(s) provided: ☐ YES ☐ NO

This includes lab results, medications or any other pertinent information about your health care and health records.

RESTRICTIONS ON THE USE & DISCLOSURE OF YOUR HEALTH INFORMATION

I understand that I may request certain restrictions on the use and disclosure of my health information.
I REQUEST THE FOLLOWING RESTRICTIONS:

☐ Mental Health Records

☐ Communicable diseases including, but not limited to, HIV/AIDS, Alcohol/Drug abuse, Genetic information

☐ Other (Specify) _____

_____ _____

Signature of Patient Date

I understand that I can revoke this authorization to share my health data at any time by submitting a request in writing to: ***TREASURE COAST URGENT CARE***

TREASURE COAST Urgent Care

Medical Records Custodian Office
1050 SE Monterey Rd. Suite 101 • Stuart, FL 34994 • **772-419-0560**
www.**tcurgentcare.com** | Secure Fax: **772-403-2379**

MEDICAL RECORDS RELEASE

The following patient requested that their records be released as listed below.

RE: PATIENT: _____ DOB: _____ / _____ / _____

SSN: _____ DATES NEEDED: _____ ☐ ALL

RELEASE RECORDS FROM: _____

ADDRESS: _____

_____

PHONE: _____ FAX: _____

RELEASE RECORDS TO: _____

ADDRESS: _____

_____

PHONE: _____ FAX: _____

Health Information to be disclosed upon the request of the person named above.

☐ **Disclose my complete health record**
(Including but not limited to diagnoses, lab tests, prognosis, treatment and billing for ALL conditions)

☐ **Disclose my health record as above <u>BUT DO NOT INCLUDE</u>**

☐ Mental Health ☐ Alcohol/Drug Treatment

☐ Communicable Diseases (including HIV & AIDS)

☐ Other (please specify) _____

FOR THE PURPOSE OF CONTINUITY OF CARE UNLESS OTHERWISE NOTED: _____

Pursuant to Florida Law, the records may be used only for the purpose provided and to whom requested. Any information may not be disclosed to any other person without the specific written consent of the undersigned. Changes are in compliance with Florida Law. I understand I may revoke this consent at any time before the information has been released.

_____ _____
Name of the Individual Giving this Authorization (print) Date of Birth

_____ _____
Signature of the Individual Giving this Authorization Date

Witness: _____ Date: _____

PATIENT PORTAL AUTHORIZATION

Authorization to disclose health information via electronic transmission

Patient Name: _____

E-mail: _____

Date of Birth: _____ / _____ / _____

By signing this form, I authorize **Treasure Coast Primary Care / Treasure Coast Urgent Care** to communicate via a personal, secured access Patient Portal with me for my medical care and treatment. Treasure Coast Urgent Care will provide notices via your personal e-mail that information can be found in your Patient Portal. No personal health information is transmitted via or into your personal e-mail. I understand that the following types of protected health information may be used, disclosed, and retained by the health care providers of Treasure Urgent Care as a result of the communications:

- **My Personal Health Information**
- **Electronic Displays of Radiological Images (X-rays)**
- **Laboratory Test Results / Pathology Reports**
- **Other Diagnostic Testing**

Patients and/or personal representatives who want to communicate with their health care providers by clinic Portal should consider all of the following issues before signing this authorization.

- Portal communication is a convenience and not appropriate for emergencies or time-sensitive issues.
- Portal Messages received by us can be forwarded, printed and/or read, and stored by our staff members.
- We advise caution when communicating highly sensitive or personal information via Portal messages.*(i.e. HIV status, mental illness, chemical dependency, and workers compensation issues)*
- Clinically relevant messages and responses will be documented in your medical record. Treasure Coast Urgent Care will not be liable for information lost or misdirected due to technical errors or failures.
- Treasure Coast Urgent Care does not own or have any interest in the Portal website. Our EMR software provides the Portal as a secure conduit in which communication with our data base is managed.
- I understand that I may revoke this authorization at any time in writing to Treasure Coast Urgent Care.
- I understand that if I revoke this authorization, it will not apply to any information already released.

I understand that I may refuse to sign this authorization and understand that Treasure Coast Urgent Care cannot deny or refuse to provide treatment, payment, or medical records if I refuse to sign this authorization.

I have read and understand the information in this authorization form.

_____ _____

Patient or legal guardian signature Date

TREASURE COAST Urgent Care

1050 SE Monterey Rd. Suite 101 • Stuart, FL 34994 • **772-419-0560**

www.**tcurgentcare.com** | Secure Fax: **772-403-2379**

PATIENT PORTAL PROCESS/INFORMATION

INFORMATION

At **Treasure Coast Urgent Care** we offer HIPAA compliant electronic access to your patient record. This is a convenient way for you to have quick and anytime access to your medical care and treatment you receive at the clinic. This secure portal is offered to you through EMD's, the electronic health record program that is used by **Treasure Coast Urgent Care**.

First, you will need to sign a portal authorization form

This is available via our website at www.tcurgentcare.com under Resources >Patient Forms. Under the tab 'Portal Authorization' click on the form to fill out in Google Chrome or other PDF viewer. You may also obtain a copy in any of our office locations.

Second, you will be emailed a registration link

Follow the directions in the email to complete the registration process. You can yuse your email address as your user name and create a password of your choice. We recommend 6-8 characters and the use of at least one capital and number.

Once completed, you will have HIPAA compliant access to your health history including medication history, secure email directly with your provider and you'll be able to request copies of your labs, make appointments, and order some medication refills. **Please treat this login information as you would any confidential login.**

TYPES OF COMMUNICATION AVAILABLE TO YOU VIA THE PORTAL:

- Send/receive messages to/from clinic staff including directly to/from your provider
- Receive lab or diagnostic test results
- Request a physician referral
- Request an appointment
- Request a refill of your medication(s)
- You can also view/update your current medication list, demographic information, and login information