Patient Registration Form

Date: ____ /____ /________ Marital Status: Single Married Divorced Separated Widowed

Last Name: ______________________________ First Name: _________________________ M.I.: _________

Maiden Name: ___________________________ Birth Date: ____ /____ /_______ Age: _________

Male Female Social Security Number: ____

Street Address: ____

City: ____________________________________ State: ________________ Zip Code: _________________

Home Phone: (______) ________ - ___________ Cell Phone: (______) ________ - ___________

Work Phone: (______) ________ - ___________ Email: ______________________@__________________

Referred by: ____

Ethnicity: (please select) Hispanic/Latino Not Hispanic/Latino Decline

Race: (please select) White Hispanic Black/African American American Indian/Alaskan Native

Asian Native Hawaiian/Pacific Islander **Preferred Language:** _____________________________

Preferred Local Pharmacy: ____

Mail Away Pharmacy: ____

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 TIME OF 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 ARRANGEMENTS HAVE BEEN MADE IN ADANCE 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 Care for any services furnished to me by that party. Regulations pertaining to Medicare assignments 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).

Insurance Information

(Please make sure that the front desk has scanned in a copy of your photo ID and insurance card)

Subscriber's Name: ___________________________________ Date of Birth: ____ /____ /________

Relationship to patient: ____________________________ Phone Number: (______) _______-__________

Please indicate primary insurance: ____

Please list secondary insurance if applicable: ____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance that is left over. I also authorize Treasure Coast Urgent Care to release any information required to process my claims.

Patient Signature: ____ Date: ______________________

Guardian Signature: ______________________________________ Date: ______________________

New Patient Medical History Form

First Name: ________________________ Last Name: _________________ Date of Birth: ____/____/______

Reason for today's visit:

____

____

Allergies: PENICILLIN SULFA ASPIRIN IBUPROFEN IODINE Others:

____

____

Current Medications:

Name	Dosage	How many do you take & how many times per day
_____________________	__________	____
_____________________	__________	____
_____________________	__________	____
_____________________	__________	____
_____________________	__________	____
_____________________	__________	____
_____________________	__________	____
_____________________	__________	____
_____________________	__________	____
_____________________	__________	____
_____________________	__________	____

Past Medical History: (Please mark any conditions that you have had or have)

Abnormal EKG	Anemia	Asthma	Breast Lump
Cancer: ___________	Coronary Artery Disease	Depression	Diabetes Type I or II
High Cholesterol	Emphysema	Heart Attack	Hepatitis (type: _______)
High Blood Pressure	Hyperthyroidism	Hypothyroidism	Kidney Disease or Stones
Mental Illness	Migraines	Osteoarthritis	Osteoporosis
Seizures	Stomach Ulcer	Stroke	Tuberculosis

Please list any others or clarification of anything circled above:

____
____
____

Surgical History:

Have you ever had surgery? YES NO

If yes, please list the surgery and the date below. If you are not sure of the date, please give approximation.

Date **Surgery**

____
____
____
____
____
____
____
____

Family History:

If any of your close family members (grandparents, parents, siblings, children, aunts, and uncles) have had any of the conditions listed below. **Please be sure to list if the member is paternal or maternal when necessary**.

Cancer (list type, if known): ____

Diabetes (list type, if known): ____

Heart Disease/High Blood Pressure: ____

Stroke: ____

Thyroid Disease: ____

Mental Health History: ____

Health Habits:

Smoking

Have you ever smoked? Never Former Current

If yes, how many years have you smoked or did you smoke? __________ If you did quit, what year? _______

Former or current smokers, please answer the amount: ______________ packs per day

Caffeine

Do you drink caffeinated beverages? YES NO Decaffeinated Only

Coffee: How many on average per day __________ week __________

Tea: How many on average per day __________ week __________

Soda: How many on average per day __________ week __________

Alcohol

Do you drink alcoholic beverages? YES NO Former Alcoholic

If yes, what beverage do you typically drink? _____________________________

How many on average per day __________ or week __________ or month __________

Exercise

Never 1 x week 2-3 x week 4-5 x weekDaily

Preferred exercise routine: ____

Substance Abuse

Do you have any history of substance abuse? YES NO

If yes, please list the substance(s): ____

Mental Health

Do you have any history of mental illness? YES NO

If yes, please list the illness(s): ____

Communicable Disease

Do you have any history of communicable diseases? YES NO

(this would include STD's, hepatitis, tuberculosis, etc…) If yes, please list the disease(s) below:

____

Patient Signature: ____Date: ____________________

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: **772-872-7305**

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: ____________________

TREASURE COAST
Urgent Care

1050 SE Monterey Rd. Suite 101 • Stuart, FL 34996 • **772-419-0560**
www.**tcurgentcare.com** | Secure Fax: **772-872-7305**

HIPAA PRIVACY RELEASE

PERMISSION TO SHARE YOUR PRIVATE HEALTH INFORMATION

I understand my medical records are protected by federal law and that information can only be released as per the Health Information Privacy and Portability Act.

____

Patient Name

☐ **I DO NOT AUTHORIZE TO SHARE MY PRIVATE HEALTH INFORMATION**
If checked, please sign the form below

☐ **I AUTHORIZE TREASURE COAST URGENT CARE TO SHARE MY PRIVATE HEALTH INFORMATION**
If checked, please provide the information below

SHARE MY PRIVATE HEALTH INFORMATION WITH THE FOLLOWING INDIVIDUAL(S):
Please list Name & Phone Numbers

NOTICE OF VOICEMAIL AND MESSAGES

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

* RESTRICTIONS ON INFORMATION TO BE DISCLOSED

I request the following restrictions on the information disclosed:

☐ Mental Health Records
Do not disclose these records

☐ Communicable Diseases, including HIV/AIDS, Alcohol/Drugs, Genetics
Do not disclose these records

☐ Other ____
Do not disclose these specified records

____ ____________________

Patient Signature Date

I understand I can revoke this authorization at any time by submitting a request in writing to **Treasure Coast Urgent Care**.