TREASURE COAST Urgent Care

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: _____

TREASURE COAST Urgent Care

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:

<u>Smoking</u>

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 BUT DO NOT INCLUDE**

☐ Mental Health ☐ Alcohol/Drug Treatment

☐ Communicable Diseases (including HIV & AIDS)

☐ Other (please specify) _____

*PLEASE MAIL IF OVER 25 PAGES

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: _____

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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

Emailed COVID-19 results may be sent without HIPAA Encryption requirements: ☐ 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**.