

# URGENT TREATMENT CLINICS REGISTRATION FORM

Patient Information					
Today's Date	Home Phone	Cell Phone	Alt. Phone	Email Address	
<b>Reason for Visit</b>					
Last	First	Middle	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital Status	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former Name)	Birth Date	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Street Address	Apt #	City	State	Zip	Social Security #
<b>Emergency Contact</b>		<b>Relationship</b>		<b>Phone Number</b>	
<b>Pharmacy Used for Medicines</b>		<b>Location of Pharmacy</b>		<b>Phone #: (if known)</b>	
<b>Primary Care Physician:</b>		<b>Address:</b>		<b>Phone#:(if known)</b>	

Billing Information		
Health Insurance Provider	ID#	Group #
<b>Cardholder's Name</b>		<b>Cardholder's Date of Birth</b>

Assignment and Release of Benefits		
<p>The above information is true to the best of my knowledge. I, the undersigned, certify that I (or my dependent) have insurance with _____ and assign directly to Urgent Treatment Clinics all insurance benefits, if any, payable for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize, Urgent Treatment Clinics to release all necessary information to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.</p>		
Responsible Party Signature	Relationship	Date

Patient Billing Information			
Employer	Occupation	Employer Phone No.	
<b>Employer Address</b>			
Secondary Insurance (if applicable)	Subscriber's Name	Group #	Policy #
Person responsible for Account (other than self)		Relationship	
Address (if different)		State	Zip
Responsible Person's Home Phone	Other Phone	Date of Birth	Social Security Number
Responsible Person's Employer		Responsible Person's Employer's Address	
City	State	Zip	Phone Number
<b>Have you ever been treated at an Urgent Treatment Clinic before? _____ Which location? _____</b>			
<b>Have you ever been treated at <u>this</u> Urgent Treatment Clinic before? _____</b>			

# Medical History and Assessment Form

Date: \_\_\_\_\_ Name (Last, First, Middle) \_\_\_\_\_ DOB \_\_\_\_\_

Phone Number: \_\_\_\_\_ Date Last Seen: \_\_\_\_\_ Date of Last Physical: \_\_\_\_\_

Date of Last Tetanus: \_\_\_\_\_ Flu Vaccine: \_\_\_\_\_ Pneumonia Vaccine: \_\_\_\_\_ Hep. B Vaccine: \_\_\_\_\_

Date of Last Mammogram: \_\_\_\_\_ Pap: \_\_\_\_\_ Cancer Screening: \_\_\_\_\_

Date of Last Hemocult: \_\_\_\_\_ PSA/DRE (Prostate): \_\_\_\_\_ Are you allergic to Latex? \_\_\_\_\_

Medication Allergies: \_\_\_\_\_

### Past Medical History (Check If You Ever Had)

✓	Asthma	✓	Diabetes	✓	Heart Attack	✓	Seizures
	Anemia		Emphysema		High Blood Pressure		Stroke
	Blood Clots		GERD		High Cholesterol		Thyroid Disease
	Congestive Heart Failure		Glaucoma		Kidney Stones		Ulcers
	Other						

Current Medications	Dose	Frequency	Surgeries (List Type and Date)
1.			1.
2.			2.
3.			3.
4.			4.
5.			5.
6.			6.
7.			7.
8.			8.
9.			9.
10.			10.

Family History	Father	Mother	Sibling	Other	What Kind
Diabetes					
Cancer					
Heart Disease					
Death Before Age 50					
High Cholesterol					

Tobacco:  Never Quit in (yr) \_\_\_\_\_ Cigs/Packs Per Day: \_\_\_\_\_  Cigars  Chew or Snuff  
(Please Circle Above) (Please Circle Above)

Alcohol:  Never Drinks Per Day: \_\_\_\_\_ Week: \_\_\_\_\_ Month: \_\_\_\_\_ Illicit Drugs:  Yes  No

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and its my responsibility to inform this office of any changes in my medical status.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

# Urgent Treatment Clinics

## Consent to Treatment

I voluntarily authorize the rendering of such care, including diagnostic procedures and medical treatment, by authorized agents and employees of the Urgent Treatment Clinic and its medical staff, designees, as may in their professional judgment be deemed necessary or beneficial, and may include testing for HIV (the virus that causes AIDS) and other blood borne diseases. I acknowledge that no guarantees have been made as to the effect of such examination or treatment on my condition. I understand that I have the right to make decisions concerning my health care or the health care of the person for whom I am duly authorized to make decisions, including the right to refuse medical and surgical procedures. I certify that I have read and understand the authorization given and I am the patient, or I am duly authorized by the patient to execute this consent and accept its terms. I also understand that this consent may be revoked at any time, except to the extent that action has already been taken, by the patient/duly authorized agent and will expire automatically **ONE** year from the date below.

## Advanced Directives

\_\_\_\_\_ **I have formulated** Advanced Directives (Living Will, Health Care Surrogate Declaration, Durable Power of Attorney), and request that these directives govern my course of care, in as much as is possible under state and federal law. I understand that it is my responsibility to provide the Hospital or UTC with a copy of my Advanced Directives and that those directives will not govern my course of care until they have been filed in my medical record.

\_\_\_\_\_ Advanced Directives **Attached**

\_\_\_\_\_ Advanced Directives **Not Attached**

\_\_\_\_\_ **I have not formulated** Advanced Directives (Living Will, Health Care Surrogate Declaration, Durable Power of Attorney), but I understand that it is my right to make decisions regarding my course of treatment, including the execution of advanced directives. I certify that I have read and understand the authorization given and I am the patient, or I am duly authorized by the patient to execute this consent and accept its terms. I also understand that this consent may be revoked at any time, except to the extent that action has already been taken, by the patient/duly authorized agent and will expire automatically **ONE** year from the date below.

## Pain Management Policy

We feel that for chronic pain management, the patient should be followed by his or her own doctor or by a pain management center for long term control of pain. Our doctors will not be prescribing any narcotics, nerve pills, muscle relaxants, and etc. for any patient on the first or subsequent visit. This office issues narcotic prescriptions only as a last resort and only for a very short term for those who require them for acute injuries or other medical conditions. If you have any questions, please do not hesitate to ask a staff member.

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ SS # \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

# UTC

## URGENT TREATMENT CLINICS

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### RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

**In accordance with the federal governments Privacy Standard for Individually Identifiable Health Information, please provide us with the requested information and sign below:**

- **The following family members can call to get my test results:**
  1. \_\_\_\_\_
  2. \_\_\_\_\_
  3. \_\_\_\_\_
  
- **Is it OK to leave a message for you on your answering service?**

Yes                      No

**Phone #:** \_\_\_\_\_
  
- **The following family members/friends are able to pick up x-rays, sample medications or prescriptions for me:**
  1. \_\_\_\_\_
  2. \_\_\_\_\_
  3. \_\_\_\_\_
  
- **I have received a copy of the Urgent Treatment Clinic's Notice of Privacy Practices.**

**Patient Name:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# Non-Covered Release Form

**Site Name:** URGENT TREATMENT CLINICS - \_\_\_\_\_  
Location of Clinic

**Patient Name:** \_\_\_\_\_

**Patient S.S. #:** \_\_\_\_\_ **Patient D.O.B.** \_\_\_\_\_

**Patient Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**Responsible Party: (if not same as patient):** \_\_\_\_\_

**Social Security # of Responsible Party:** \_\_\_\_\_

**Driver's License # and State:** \_\_\_\_\_

I have been notified that my insurance may/does not cover services for today's visit and I understand I am financially responsible for all incurred charges.

I further understand that I must pay the charges in full at the time of service.

\_\_\_\_\_  
**Signature of Responsible Party**

\_\_\_\_\_  
**Date**