CRESTVIEW URGENT CARE
2400 S FERDON BLVD, STE A
CRESTVIEW, FL 32536

URGENT CARE
Care at Your Convenience

PHONE: 1-850-398-8668
FAX: 1-850-398-8679
EMAIL: cuc@mylocalurgentcare.net

Patient: _____ Birth Gender: o Female o Male
Last name First name Middle Initial

Race: o American Indian or Alaska Native o Black or African American o Asian
o Hispanic or Latino o Native Hawaiian or Other Pacific Islander o White

Patient Date of Birth: _____ Social Security number: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

I authorize release of my medical information to: _____ Relationship: _____

PLEASE COMPLETE THE FOLLOWING INSURANCE INFORMATION ON THE SUBSCRIBER/SPONSOR. YOU DO NOT HAVE TO COMPLETE THIS SECTION IF YOU ARE THE SUBSCRIBER/SPONSOR:

Primary Insurance Name: _____ Secondary Insurance name: _____

Subscriber's name: _____ Subscriber's name: _____

Subscriber's DOB: _____ Subscriber's DOB: _____

Subscriber's SSN: _____ Subscriber's SSN: _____

Pharmacy (**BE SPECIFIC or we will automatically send it to the Crestview location**):

Crestview: Walmart CVS Walgreens Hometown Moulton's

Publix Bent Creek Publix North Genoa Health Smart (Baker) **IWP (Work Comp Patients ONLY)

**IWP is a mailing service that sends medication directly to your home the following day after your visit.

Other pharmacy and location: _____

Emergency Contact: _____ Phone #: _____ Relationship: _____

FLIP OVER

AUTHORIZATION TO TREAT

I understand that this authorization includes my consent for medical tests, procedures, drugs and other services and supplies as considered advisable. This treatment may include, but is not necessarily limited to, anesthesia, pathology, radiology and other imaging and diagnostic services, and other special tests and services including tests for communicable diseases and toxins, as ordered by the physician responsible for my care during my visit. I acknowledge that the practice of medicine is not an exact science and no guarantees or promises have been made to me as to the results of examination, care, or treatment. I acknowledge that it is important for me to provide accurate and complete information regarding my symptoms, medications, drug use, and other information, and that failure to do so can adversely impact my care.

Some insurance companies require pre-authorization services. If I am required to obtain an authorization for today's visit and have not done so, I agree to assume all financial responsibility. If I receive any additional services from specialists, hospitals, or other healthcare providers in connection with, or as a result of this visit, those charges may also be my responsibility, unless preauthorized as required by my insurance company. I authorize the release of medical or other information to my insurance company, the Center for Medicare and Medicaid Services, or its carriers as necessary to determine payment for these or related services. Certain lab tests may be sent to an independent lab for processing. I understand I may receive a separate bill for these services. In the event that collection procedures are initiated on any outstanding balance, I agree to be responsible for the costs of collection including, but not limited to: court costs, expenses, and attorney fees, to the extent permitted by law. I understand that the foregoing provision applies equally to myself or any individual for whom I am authorizing treatment.

ASSIGNMENT OF BENEFITS

The undersigned patient hereby assigns the benefits of insurance under the applicable health/automobile insurance policy to **Crestview Urgent Care, Inc.** and all locations for services rendered to the undersigned patient and covered by health insurance, PIP coverage, and/or Medical Payments coverage. This is a direct assignment of my rights, causes of action, and benefits under the applicable automobile insurance policy. The undersigned further agrees to pay any applicable deductible or co-payment not covered by Auto Insurance or Medical Payments Coverage.

CONSENT FOR RELEASE OF HEALTH/MEDICAL INFORMATION

I hereby acknowledge I am providing this authorization to representatives of Crestview Urgent Care.

I hereby give my consent to use and disclose protected health information (PHI) about me to carry out treatment or payment health care operations (TPO). I have the right to review the Notice of Privacy Practices prior to signing this consent. All rights are reserved to revise the Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request. With is consent, representatives may call my home or other alterative location and leave a message on voice mail or in person in reference to any items that assist in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others. With this consent, representatives may mail to my home or other alternative location any items that assist in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential". I have the right to request restrictions regarding how it uses or discloses my PHI to carry out TPO. The Center is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do not sign this consent, or later revoke it, treatment may be declined.

Patient or Guardian/Parent Signature: _____ **Date:** _____

Patient's Name: _____ Today's Date: _____

Date of Birth: _____ Sex: _____ Marital Status: _____

Employment Status: _____ Employer Name: _____

Do you reside in an assisted living facility? o Yes o No Do you live alone? o Yes o No

DO NOT LEAVE ANY SECTION BLANK – IF ANY SECTION DOES NOT APPLY PLEASE INPUT "N/A"

Reason for today's visit (please include **SYMPTOMS**):

_____

_____

_____

_____

How long have you been experiencing today's complaint? _____

Please list **ALL** allergies to medications only:

_____

_____

Medication List: We must have dosages and frequency of use listed
IF YOU DO NOT KNOW PLEASE CONTACT YOUR PHARMACY:

NAME OF MEDICATION	DOSE & FREQUENCY OF USE	REASON FOR USAGE

If you do not take any prescribed medication please check here: ☐ Are immunizations up to date? o Yes o No

FLIP OVER

Please circle any of the following conditions are you currently being treated for, or have been treated for in the past:

Heart Disease	Psychiatric Care	Asthma	Eye Issues/Glaucoma	Neurological Issues
Heart Angina	Kidney/Bladder	Headaches/Migraines	Heartburn/Reflux	Thyroid Issues
Heart Murmur	Cancer	Season Allergies	Lung Issues/Cough	Blood Pressure Issues
Seizures	Shortness of Breath	Depression/Anxiety	Stroke	Sinus Issues
Swollen Ankles	High Cholesterol	Ulcers/Colitis	Tonsillitis	Anemia / Blood Issue
Liver Issues	Hepatitis	Arthritis	Ear Issues	Diabetes

If you have circled any conditions in the previous section, please explain:

_____

_____

_____

Please describe any current or past medical treatment not listed in previous section:

_____

_____

_____

Please list **ALL** previous surgeries:

_____

_____

_____

	YES	NO
Do you currently smoke?		
Have you smoked in the past? (No if smoked less than 100 cigarettes in lifetime)		
Do you currently chew tobacco?		
Have you chewed in the past?		
Do you drink alcohol, beer, or wine?		
Any recreational drug usage?		

If you marked yes to any question above, please explain and list frequency of use (per day/week):

_____

_____

Females:

When was the first day of your last menstrual period? __/__/____

Are you currently pregnant? o Yes o No If **PREGNANT,** how many weeks? _____

Are you currently breastfeeding? o Yes o No