PREMIER URGENT CARE
WE CARE

PATIENT REGISTRATION INFORMATION

Patient's Name (Last, First, M.I.):			
Mailing Address:			**Apt. #:**
City:		**State:**	**Zip:**
Marital Status: □ Single □ Married □ Widowed □ Divorced □ Separated			
Social Security No.:	**Date of Birth:**	**Age:**	**Sex:** □ Male □ Female
Phone# (Home):	**Phone # (Cell.):**	**E-Mail:**	
Employer:		**Employer Phone #:**	
Employer Address:			
Emergency Contact:	**Relationship:**	**Phone #:**	
If patient is a minor under the age of 18, are you the the legal guardian? □ Yes □ No **If not, who is?**			
Race/Ethnicity: □ African American □ Caucasian □ Asian □ Pacific Islander □ American Indian □ Alaskan Native □ Hispanic □ Other			

INSURANCE COVERAGE

PRIMARY INSURANCE		SECONDARY INSURANCE	
Ins. Co. Name:		**Ins. Co. Name:**	
PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD		**PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD**	
ID #:		**ID #:**	
Group #:		**Group #:**	
Subscriber's Name:		**Subscriber's Name:**	
Relationship to Patient: □ Self □ Spouse □ Parent		**Relationship to Patient:** □ Self □ Spouse □ Parent	
Address:		**Address:**	
Employer:		**Employer:**	
Subscriber's Soc. Sec. #:	**DOB:**	**Subscriber's Soc. Sec. #:**	**DOB:**

CONSENT TO TREAT

I consent to my medical or surgical treatment as determined necessary by the Premier Urgent Care health care provider.

Signature of Patient / Guardian / POA: **X** **Date:**

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign any and all insurance benefits payable to me, which are applicable to the patient account, but not to exceed the outstanding balance on my accont. Should this account have to be turned over for collection, I agree to pay all reasonable attorney fees, court costs, and/or collection fees necessary to collect the past due balance on this account. I understand that Premier Urgent Care will bill my insurance as a courtesy to me. I will notify Premier Urgent Care in writing of any change in insurance information or coverage. If payment is not received within 45 days from the date of the bill I understand that I am financially responsible for all services rendered to aforementioned patient by Premier Urgent Care.

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my or my minor child's medical status.

Signature of Patient / Guardian / POA: **X** **Date:**

ACKNOWLEDGEMENT OF PRIVACY PRACTICES NOTICE

I acknowledge that I have received a copy of Premier Urgent Care Notice of Privacy Practices in accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Signature of Patient / Guardian / POA: **X** **Date:**

HEALTH QUESTIONNAIRE

Name: _____ **Date:** _____

Past Medical History:

PRE-EXISTING CONDITIONS:

Have you sought care for any health condition in the past 3 years? □ Yes □ No

If yes, what condition(s)?_____

What treatment was administered?_____

_____

Do you take medication for any condition? □ Yes □ No

if yes, what medication(s)?_____

_____

Have you ever had a surgery? □ Yes □ No

If yes, what type of surgery?_____

_____

Social History:

Alcohol: □ Yes □ No If yes: □ Rare □ Social □ Daily

Smoke: □ Yes □ No If yes: How many packs per day _____.

Illicit Drugs: □ Yes □ No If yes:_____.

Family Hisory:

Hypertension: □ Mother □ Father □ Sibling

Diabetes: □ Mother □ Father □ Sibling

Cancer: □ Mother □ Father □ Sibling

Cardiac Issues: □ Mother □ Father □ Sibling

Stroke: □ Mother □ Father □ Sibling

Mental Illness: □ Mother □ Father □ Sibling

SYSTEMATIC REVIEW

GENERAL:
Fever: □ Yes □ No
Unusual Weight Loss: □ Yes □ No
Weakness: □ Yes □ No

HEENT:
Blurred Vision: □ Yes □ No
Double Vision: □ Yes □ No
Glaucoma: □ Yes □ No
Eye Injury: □ Yes □ No
Eye Disease: □ Yes □ No

NECK:
Stiffness: □ Yes □ No
Pain: □ Yes □ No
Thyroid Disorder: □ Yes □ No
Enlarged Glands: □ Yes □ No

CARDIO VASCULAR:
Chest Pain: □ Yes □ No
Shortness of Breath: □ Yes □ No
High Blood Pressure: □ Yes □ No
Conjestive Heart Failure: □ Yes □ No
Heart Murmor: □ Yes □ No
A-Fib: □ Yes □ No
Pacemaker: □ Yes □ No

GASTROINTESTINAL:
Nausea: □ Yes □ No
Vomiting: □ Yes □ No
Diarrhea: □ Yes □ No
Constipation: □ Yes □ No
Blood in stool: □ Yes □ No
Heartburn: □ Yes □ No
Gallbladder disease: □ Yes □ No
Liver Disease: □ Yes □ No
Hepititis: □ Yes □ No

SKIN:
Abnormal pigmentation: □ Yes □ No
Urticaria (Hives): □ Yes □ No
Eczema: □ Yes □ No
Rash: □ Yes □ No
Ecchymosis □ Yes □ No

RESPIRATORY:
Chronic Cough: □ Yes □ No
Asthma: □ Yes □ No
Wheezing: □ Yes □ No
Pleurisy: □ Yes □ No
Pneumonia: □ Yes □ No
Shortness of breath: □ Yes □ No

NEUROLOGICAL:
Headaches: □ Yes □ No
Confusion: □ Yes □ No
Dysarthria: □ Yes □ No
Weakness: □ Yes □ No
Numbness: □ Yes □ No

PSYCHOLOGICAL:
Anxiety: □ Yes □ No
Depression: □ Yes □ No
Mood Changes: □ Yes □ No

ALLERGIES:
Allergies to Medication: □ Yes □ No
If yes which Medication _____
_____

HEMATOLOGICAL:
Are you slow to heal
after cuts?: □ Yes □ No
Blood disease: □ Yes □ No
Anemia: □ Yes □ No
Phlebitis: □ Yes □ No
Have you had any abnormal
bruising of bleeding?: □ Yes □ No

CONTRACT FOR CONTROLLED SUBSTANCES

Controlled substance medications (narcotics and benzodiazepines) may be very useful, but have a high potential for misuse and abuse and are, therefore, closely controlled by the state and federal governments. Used properly, they are very effective medications. If used excessively, however, they may cause adverse effects. To insure these medications are used properly, I agree to the following conditions:

1. I am responsible for my controlled substance medications. If the prescription or medication is lost, misplaced, or stolen, or if I use it up sooner than prescribed, I understand that it will *not* be replaced.

2. I will not request, nor accept, controlled substance medication from any other provider while I am receiving such medication from Premier Urgent Care, except if I am a patient in a hospital. Besides being illegal (NRS 453.391), it may endanger my health.

3. **REFILLS of controlled substance medications and tranquilizers will REQUIRE an IN-OFFICE visit during regular office hours of MONDAY through FRIDAY 9AM to 5PM.**

4. I understand that during my treatment if at any time I am referred to a Pain Management specialist or I establish a Pain Management specialist, I will no longer receive narcotic medications from Premier Urgent Care. (NRS 453.391).

5. I understand that if I violate any of the above conditions, or decline to take a urine drug test at my provider's request, my controlled substance prescriptions will end immediately. If the violation involves obtaining controlled substance medications from another individual, as described above, I may also be reported to my primary provider (physician, physician assistant, or nurse practitioner), local medical facilities, and other authorities.

6. I understand that a drug screening will be performed at every visit, and also to obtain refills for my medications.

I have been informed by my provider about narcotic and tranquilizer effects, including normal physiological effects of tolerance (need for more medicine to achieve the same pain relief) and dependence (withdrawal will occur if I stop the medicine abruptly) and addiction (abnormal psychological dependence.)

Patients Printed Name	Patients Signature	Date & Time
Witness Printed Name	Witness Signature	Date & Time