PATIENT REGISTRATION & CONSENT TO TREATMENT

If you are experiencing life threatening symptons please alert the front desk immediately.

Last Name:______________________ First Name:____________________ MI:__________________

Preferred Name:____________________ DOB: __________ Sex:_________ Preferred Sex:_______________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partnership

Address: __________________________________ City:_______________ State: ____ Zip Code:_____

Home Phone: __________________ Cell Phone: ____________________ Email:__________________

Pharmacy Name: ______________________________ Pharmacy Location & Phone # __________________

EMERGENCY CONTACT

Name__________________________ Relationship___________________ Phone:_____________

PRIMARY INSURANCE

Insurance Company Name:______________________

Address: ______________________________

City: ________________ State________ Zip ________

Phone #________________________

Policy Holder Name: __________________________

Birth Date: __________ Relationship________________

Policy # ______________________________

Group # ______________________________

SECONDARY INSURANCE

Insurance Company Name:______________________

Address: ______________________________

City: ________________ State________ Zip ________

Phone #________________________

Policy Holder Name: __________________________

Birth Date: __________ Relationship________________

Policy # ______________________________

Group # ______________________________

PATIENT MEDICAL HISTORY

Please list any medications or dietary supplements you are taking:

____

____

____

Allergies

Allergy Type: ☐ Food (list foods)__________________________

☐ Insect sting (list insects)______________________

Reactions: List date of last occurance if any.

☐ Coughing________ ☐ Hives________ ☐ Rash ___________

☐ Difficulty breathing__________ ☐ Local swelling ___________

☐ Wheezing________ ☐ General swelling________________

☐ Nausea_________ ☐ Other_______________________

Current prescribed medications:

☐ Oral antihistamine ☐ Epi-pen ☐ Other:_______________

List any assistive devices you are using (braces, crutches, shoe inserts):

____

Have you completed advanced medical directives? (aka: "living will")

☐ Yes ☐ No

Do you have difficulties with? (check all that apply)

☐ Communication ☐ Vision ☐ None

☐ Speech ☐ Hearing

☐ **Asthma.** Please check off triggers:

☐ Environmental (tobacco, dust, pollen, etc.) ☐ Other:__________

Symptoms:______________________________

☐ **Seizure Disorder.** Please check type of seizure:

☐ Absence (staring, unresponsive) ☐ Complex Partial

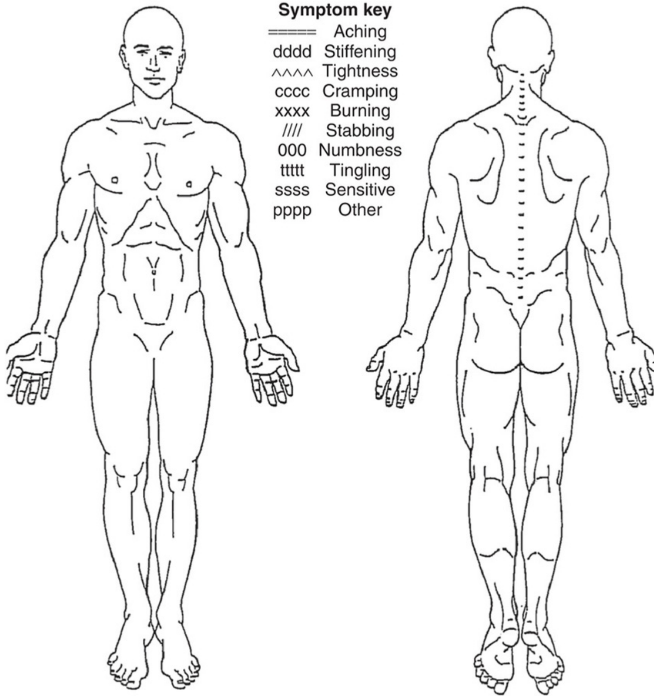
☐ Generalized Tonic-Clonic (Grand Mal/Convulsive)

☐ Physical Education Restrictions: ☐ Yes ☐ No

☐ Physical Disability (please explain)________________

continue on other side

Circle the location of pain on the chart and list the type below:



Type of pain:

____

Rate your level of pain in the last 72 hours. Circle one.

0 1 2 3 4 5 6 7 8 9 10

No pain — Worst pain imaginable

Additional Comments:

____

____

Medical History	Self		Family	
Cancer?	Yes	No	Yes	No
Diabetes?	Yes	No	Yes	No
High Blood Pressure?	Yes	No	Yes	No
Heart Disease?	Yes	No	Yes	No
Rheumatoid Arthitis?	Yes	No	Yes	No
Neurological dz (MS,Parkinsons)?	Yes	No	Yes	No
Ulcers/GERD/Acid Reflux?	Yes	No	Yes	No
Kidney/Liver Disease?	Yes	No	Yes	No
Prior Surgeries?	Yes	No	Yes	No
Other:____________________	Yes	No	Yes	No

In the past 3 months have you had or do you experience:

Changing in your general health?	Yes	No
Fever/Chills/Sweats?	Yes	No
Unexplained weight change (>10lbs)?	Yes	No
Numbness or tingling?	Yes	No
Bowel/bladder incontinence?	Yes	No
Difficulty sleeping due to pain?	Yes	No
Unexplained falls/decreased balance?	Yes	No

Are you currently/do you have:

Pregnant/Potentially Pregnant/Nursing?	Yes	No
Often bothered by feeling down, depressed or hopeless?	Yes	No
Often experience little interest or pleasure in doing things?	Yes	No
Under physical/emotional abuse?	Yes	No
Dietary or Nutritional Concerns?	Yes	No
Do you use tobacco products?	Yes	No
Do you drink alcoholic beverages?	Yes	No
Do you take illegal substances?	Yes	No

Consent to Treatment & Release of Information

By signing this enrollment and consent form, you consent to the following:

- I authorize Urgent Care Eleven (UCE) to examine and treat either myself of my child, and I understand that no guarantee has been made as to the results of such examinations and treatments.
- I authorize UCE staff members to release any medical records required by the insurer or other payer to obtain payment. I authorize that I have reviewed the UCE Notice of Privacy Practices document made available by both hardcopy and hyperlinked via the UCE website.

Revocation

I understand that this Consent Form may be revoked in writing at any time and that the revocation will take effect on the day it is received by UCE. The revocation must be in writing and signed by stated patient.

Acknowledgment

I have carefully read the foregoing Consent for Medical Treatment and fully understand the meaning of this consent form. I affirm that I have signed this authorization voluntarily.

Patient Signature______________________________ **Date**____________________

Parent or Gaurdian Signature (if minor)____________________ **Date**____________________