



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

New Patient

Please complete entire form and sign the back.

Established Patient

Please complete name and DOB and sign the back.

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 occurrence if any.

Coughing _____ Hives _____ Rash _____

Difficulty breathing _____ Local swelling _____

Wheezing _____ General swelling _____

Nausea _____ Other _____

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

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

Communication Vision

Speech Hearing

Asthma. Please check off triggers:

Environmental (tobacco, dust, pollen, etc.) Other: _____

Seizure Disorder. Please check type of seizure:

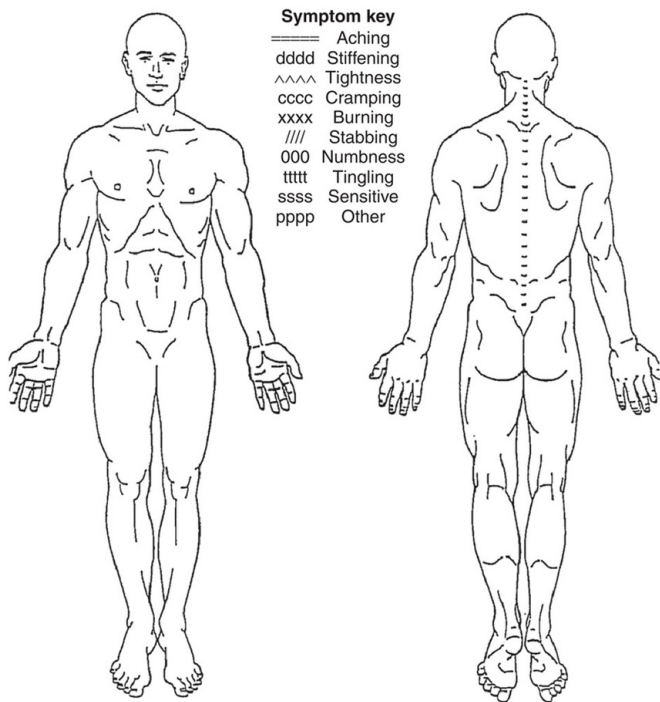
Absence (staring, unresponsive) Complex Partial

Generalized Tonic-Clonic (Grand Mal/Convulsive)

Physical Education Restrictions: Yes No

Physical Disability (please explain) _____

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 Arthritis?	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 & HIPPA Acknowledgement

By signing this form, you consent to the following:

- I received and acknowledged the Notice of Privacy Practice document made available by both hardcopy and hyperlinked via the Urgent Care Eleven (UCE) website.
- I authorize UCE to examine and treat either myself or my child, and I understand that no guarantee has been made as to the results of such examinations and treatments.
- I understand that while my insurance may confirm my benefits, confirmation of benefits does not guarantee payment, and I am fiscally responsible for any unpaid balance for all services rendered.
- I authorize UCE staff members to release any medical records required by the insurer or other payer to obtain payment.

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 _____