

Urgent Care Center

Orange Town Center
109 Boston Post Road
Orange, CT 06477
203-298-4600

PATIENT INFORMATION

(Please print)

REASON FOR VISIT _____ DATE _____

Last Name _____ First Name _____ MI _____

Home Address _____

City _____ State _____ Zip code _____ Date of Birth _____

Home Phone _____ Work Phone _____ Cell Phone _____

E-Mail Address _____ Primary Care Physician _____

Social Security # _____ Gender M F Marital Status S M D W O

Emergency Contact _____ Relationship _____ Phone _____

HOW DID YOU HEAR ABOUT OUR URGENT CARE CENTER _____

INSURANCE INFORMATION

Primary Insurance _____

Policy ID _____ Group # _____ Member # _____

Name of Policy Holder _____ Relationship _____

Secondary Insurance _____

Policy ID _____ Group # _____ Member # _____

Name of Policy Holder _____ Relationship _____

GUARANTOR'S INFORMATION

Guarantor's Last Name _____ First Name _____ MI _____

Guarantor's Home Address _____

Guarantor's Phone # _____ Policy Effective Date _____

Guarantor's DOB _____ Gender M F Relationship to Patient _____

Urgent Care Center

REASON FOR VISIT _____ DATE _____

Name _____ Date of Birth _____

CURRENT MEDICATIONS

Drug:	Dosage:	Frequency:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

CURRENT ALLERGIES

Food: Egg Fish Milk Peanut Shellfish Tree nuts Wheat Other _____
Environmental: Bee sting Dust Pollen Ragweed Other _____
Drugs: _____

MEDICAL HISTORY

Acid Reflux Anemia Asthma Cancer (type) _____ Heart Disease Depression
 Diabetes High Blood Pressure High Cholesterol Kidney Disease Seizures Thyroid Disease
 Other (explain): _____

SURGICAL HISTORY

Type:	Date:
_____	_____
_____	_____
_____	_____

FAMILY HISTORY

Alcoholism Anemia Asthma Cancer (type) _____ Depression Diabetes
 Heart Disease High Blood Pressure High Cholesterol Kidney Disease Thyroid Disease
 Other (explain): _____

SOCIAL HISTORY

Occupation: _____ Full-time Part-time
Smoker? Yes No # of packs per day _____
Alcohol Abuse? Yes No
Substance Abuse? Yes No

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AUTHORIZATION AND RELEASE

Authorization for Treatment: I voluntarily consent to the administration and cost of medical and surgical procedures for myself or my dependent.

Assignment of Insurance Benefits: I authorize payment directly to Urgent Care Center, LLP for all benefits otherwise payable to me.

Guarantee of Payment: I understand that I am financially responsible and agree to pay all charges that are not paid or billed to insurance or any third party payer. I understand that I must pay in full today, for all services rendered unless my insurance is accepted. I also understand that if my insurance is accepted, I must pay all applicable insurance co-pays, or co-insurance, and deductibles today. If you are unable to verify my insurance at time of service, I will pay in full for all services.

Release of Records: I authorize Urgent Care Center, LLP to release (verbal or written) confidential medical information to any person or entity including my insurance carrier, employer if treatment is related to employment purposes, or other healthcare operations which may be liable to me or my practitioner(s) for charges for this treatment and for quality management, utilization review, transfer, and follow-up purposes.

Receipt of Privacy Practices: I acknowledge that I have received and read the Notice of Privacy Practices of Urgent Care Center, LLP. I understand that a copy of this agreement may be used with the same effectiveness as the original.

PATIENT SIGNATURE: _____ **DATE:** _____

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

CONSENT FOR NOTIFICATION OF TEST RESULTS

I give permission to Urgent Care Center, LLP to notify _____ relationship _____ my health information.

PATIENT SIGNATURE: _____ **DATE:** _____

I give permission to Urgent Care Center to leave any health information on my answering machine.

PATIENT SIGNATURE: _____ **DATE:** _____

Urgent Care Center

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This document is to be signed by the patient legally responsible for the patient's medical decisions relative to the treatment situation.

I, _____, hereby acknowledge Urgent Care Center, has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact:

Philip Noto, Administrative Director
203-298-4600

I also understand that I am entitled to receive updates upon request if and when Urgent Care Center amends or changes its Notice of Privacy Practices in a material way.

Signature

Relationship to Patient, if signed by someone other than patient.

Date

IF WE WILL BE PHONING YOU REGARDING AN APPOINTMENT, LAB OR OTHER TESTS OR CONSULTATIONS, I PREFER THAT YOU CALL MY:

___ Home Telephone ___ Work Telephone ___ Cell Phone

THIS SECTION IS TO BE COMPLETED BY URGENT CARE CENTER IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM PATIENT.

I made a good faith effort to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from above-named patient, but was unable to because:

[] Patient declined to sign Written Acknowledgement

[] Other (specify)

Name and title of employee

Date