Niagara Falls Urgent Care Patient Registration

1. PATIENT INFORMATION (please print as neatly as possible)

☐Dr. ☐Miss ☐Mr. ☐Mrs. ☐Ms. ☐Sir ☐ I'm a Jr. ☐ I'm a Sr.

Patient's Name: (Last) _____ (First) _____ (MI) _____

Mailing Address _____ City, State, ZIP _____

Home Phone _____ Cell Phone _____ Work Phone _____

Date of Birth (MM/DD/YYYY) _____ Sex: ☐ Male ☐ Female ☐ Other _____

Social Security Number _____ Primary Care Provider (PCP) _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

E-mail Address _____ ☐ I don't want to provide my email

Language _____ Race _____ Ethnicity _____

2. EMERGENCY CONTACT INFORMATION ☐ I don't want to list an emergency contact

Emergency Contact Name _____ Phone Number _____

Emergency Contact Relationship to Patient _____ ☐ Guardian

Address _____ City; State; Zip:_____

3. RESPONSIBLE PARTY INFORMATION

Responsible Party: ☐ Self ☐ Another Patient ☐ Guarantor Check here if information is same as patient ☐

Responsible Party Name: (Last) _____ (First) _____ (MI) _____

Date of Birth (MM/DD/YYYY) _____ ☐ Male ☐ Female Phone # _____

Mailing Address _____ City, State, ZIP _____

Patient Relationship to Responsible Party _____

4. PRIMARY INSURANCE INFORMATION (please provide your driver's license & insurance card to the front staff)

Insurance Company _____ Their Phone # _____

Name of Insured _____ Patient Relationship to Insured _____

Subscriber ID (Policy Number) _____ Person Code _____ Group ID _____

Insured Date of Birth _____ Insured's Social Security Number _____

SECONDARY INSURANCE INFORMATION (if applicable)

Insurance Company _____ Their Phone # _____

Name of Insured _____ Patient Relationship to Insured _____

Subscriber ID (Policy Number) _____ Person Code _____ Group ID _____

Insured Date of Birth _____ Insured's Social Security Number _____

5. PHARMACY INFORMATION

Pharmacy Name _____ Their Phone # _____

Address _____ City; State; Zip _____

****I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.****

Patient (or Responsible Party) Signature _____ Date _____

>>>>>>>>>>THERE IS A BACK SIDE TO THIS SHEET. PLEASE TURN OVER<<<<<<<<<<

Name: _____ **Height:** _____ ft _____ in **Weight:** _____ lbs

What brings you in today? _____

How long has it been going on? _____

List the name, dosage, and frequency of the medications you are currently taking: ☐ I don't take any medications

Current Medications	Dosage	Frequency

Please provide your PAST MEDICAL HISTORY: ☐ I have no significant past medical history

- ☐ Allergies
- ☐ Anemia
- ☐ Angina (chest pain)
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ BPH (enlarged prostate)
- ☐ Blood clots
- ☐ Cancer, Type ____
- ☐ CVA (stroke)
- ☐ COPD (emphysema)
- ☐ CAD (heart disease)
- ☐ Crohn's disease
- ☐ Depression
- ☐ Diabetes, type_____
- ☐ Gallbladder disease
- ☐ GERD (reflux)
- ☐ Hepatitis C
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Irritable bowel syndrome
- ☐ Liver disease
- ☐ Migraine headaches
- ☐ MI (heart attack)
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Peptic ulcer disease
- ☐ Renal disease
- ☐ Seizure disorder
- ☐ Thyroid disease
- ☐ AIDS/HIV

Other past medical history:

_____

Do you have any allergies? If so, list below: ☐ No Known Drug Allergies

Allergy	Reaction or Side Effect

Please tell us about any SURGERIES you have had, and indicate the DATE/YEAR if known: ☐ None (never had any surgeries)

_____

_____

Please provide your FAMILY HISTORY: (circle your answer)

Father: ☐Alive ☐Deceased ☐Unknown Medical History: _____

Mother: ☐Alive ☐Deceased ☐Unknown Medical History: _____

Please provide your SOCIAL HISTORY:

Are you a smoker? ☐ current cigarette smoker ☐ former cigarette smoker ☐ never smoked

Do you drink alcohol? ☐ no I do not drink ☐ yes I drink socially ☐ yes I drink daily

Authorization to Treat and Acknowledgement of Financial Responsibility

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 my 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.

I request that payment authorized by my insurance company, the Center for Medicare and Medicaid Services, or its carriers, be made on my behalf for services provided. I certify that any information I provide related to my eligibility for coverage or payment is accurate and complete. I understand that it is my responsibility to notify the practice of any changes in my coverage. I understand that I am financially responsible for payment of services provided during this visit if I do not have insurance coverage or if I have coverage and timely payment is not made. I also understand that if I have a co-payment for this service or high deductible, it is payable today. I may be charged an additional fee to cover the cost of billing the co-payment, if not paid today. I understand that I am responsible for paying the amount of any discount imposed by my insurance provider or third party payer imposed discounts.

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 pre authorized 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 that 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.

Notice of Privacy Practices Acknowledgement

In general, the HIPAA Privacy Rule (Health Insurance Portability and Accountability Act of 1996 – Federal Law) gives individuals the right to request a restriction of uses and disclosures of their Protected Health Information (PHI). It also provides the right to request confidential communications between an individual and his/her physician's office.

To protect your privacy and in keeping with the Federal Privacy Law, all of your medical information, PHI, is kept strictly confidential. We will use this PHI for treatment, payment, and operations (TPO) of our medical practice. We will be required to get an authorization in writing from you if we intend to use your PHI for any other purpose.

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By signing this form, you acknowledge receipt of the **Notice of Privacy Practices** of our facility, give **Authorization to Treat**, and acknowledge your **Financial Responsibility**. Our notice of Privacy Practices is subject to change.

Printed Name: _____ Today's Date: _____/_____/_____

Signature: _____

(Patient/Parent/Legal Guardian)