Frisco Urgent Care & Clinics

PATIENT INFORMATION

Name *(First, Mi., Last)*:		Date of Birth:	Age:
Sex: Male / Female	Marital Status: S M W D		
Address:	City:	State:	Zip Code:
Home Phone #:	**Social Security #:**	Driver's License #/State	
Work #:	**Cell Phone#:**	**Email:**	
Primary Language :English/Spanish/Other	**Emergency Contact:**	**Phone #:**	

RESPONSIBLE PARTY OR SPOUSE INFORMATION

Name:	Relationship to Patient:
Phone #:	Social Security #:

Person(s)/Relationship, you authorize us to share your medical records with:

Name___________________________ **Relationship** ________________ **Tel#**____________

Name___________________________ **Relationship** ________________ **Tel#**____________

NOTE: This authorization will remain in effect until further notice from you to stop sharing your information with ove person(s)

PHARMACY NAME: ____________________ **CITY:** ____________________ **TEL#**_______________

WOULD YOU LIKE ACCESS TO PATIENT PORTAL? ____ **YES** _____ **NO**

INSURANCE INFORMATION

Primary Ins. & Address:		
Group #:	Subscriber ID # :	Phone # :
Insured's Name:		Relationship to Patient: Self / Spouse / Dependent
Insured's Social Security #:	Date of Birth:	Sex: Male / Female
Secondary Ins. & Address:		
Group #:	Subscriber ID #:	Phone# :
Sec. Insured's Name:		Relationship to Patient: Self/ Spouse / Dependent

I hereby assign, transfer, and set over to Frisco Urgent Care & Clinics all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization.

I understand that I am financially responsible for all charges whether or not they are covered by insurance.

tient's name: ____

Frisco Urgent Care & Clinics

CHIEF COMPLAINT(S): ____

If you are here due to injury or recurrent pain, what is your current pain level on a scale of 1 to 10 (1 = lowest 10=highest)? _____

CURRENT MEDICATIONS & dosages (include non-prescription):

1.	9.
2.	10.
3.	11.
4.	12.
5.	13.
6.	14.
7.	15.

PAST MEDICAL HISTORY

Please list your ***current and past medical/surgical/gynecological*** conditions

1.
2.
3.
4.

PREVIOUS SURGERIES

Type	When?	Where?
1.		
2.		
3.		
4.		

Patient's name: ____

PREVIOUS HOSPITALIZATIONS

Why? When? Where?

1.
2.
3
4.
5.
6

FEMALES — OB/GYN HISTORY

Pain with periods	no yes	Irregular Periods	no yes	Vaginal Discharge	no yes
Date of last pap smear		Abnormal Pap	no yes	Date of last mammogram	
Date of last period		Heavy periods	no yes	Hot flashes	no yes
Infertility	no yes	Sexually active	no yes		
Frequent yeast infections	no yes	PMS	no yes		
# of Pregnancies		# of Miscarriages			
# of Stillbirths					
# of abortions					

PATIENT SOCIAL HISTORY

Marital Status:	married	single	separated	divorced	widowed
Alcohol use:	never	rarely	moderate/# of drinks per day:		heavy/# of drinks per day
Tobacco use:	never	quit/when	maximum # of cigarettes/day		smoking since age
Use of drugs:	never	in the past/type	currently/type		
Current Occupation:					
Past Occupation(s) & periods:					

Do you use a seat belt while riding in a motor vehicle? Yes____ No____

Do you wear a helmet while riding a bicycle? Yes___ No___ Motorcycle: Yes___ No___

Patient's Name: ____

ALLERGIES

Please list your allergies to:

MEDICATIONS:	How did you react?
1.	
2.	
3.	
4.	
5.	
6.	

FOOD:	How did you react?
1.	
2.	
3.	
4.	

OTHERS, Ex: IV dyes	How did you react?
1.	
2.	
3.	

(Please include any reaction to rubber gloves, bottle nipples, tape, band aids, etc)

IMMUNIZATIONS

Children: Are you current? **NO / YES**. Please attach a copy of shots.

Parents: **INITIAL** here for consent to ***Add*** shot records on IMMUTRAC. ________________

Adults:

Tetanus: no yes if yes, when was the last time?

Pneumovax: no yes if yes, when was the last time?

Influenza: no yes if yes, when was the last time?

Herpes Zoster: no yes if yes, when was the last time?

Patient's name: ____

FAMILY HISTORY

	DOB	Medical/Surgical illness, if any	Alive/Deceased	Cause of death if Deceased
Mother				
Father				
Siblings				
Males				
1.				
2.				
3.				
4.				
Females				
1.				
2.				
3.				
4.				
Children				
1.				
2.				
3.				
4.				
5.				

List any other significant family history

1.
2.
3.
4.
5
6.

Do you have a working smoke and carbon dioxide detector in your home? Yes_____ No_____

Patient's name: ____

REVIEW OF SYSTEMS

1. CONSTITIUTIONAL

General good health lately	no yes
Recent weight change	no yes
Fever	no yes
Fatigue	no yes
Malaise	no yes
Headache	no yes

2 OPHTALMOLOGY

Eye disease or injury	no	yes
Wear glasses/contact lenses	no	yes
Blurred or double vision	no	yes
Eye irritation	no	yes
Drainage from eyes	no	yes
Seasonal eye symptoms	no	yes

3.ALLERGIES

Runny nose	no	yes
Scratchy throat	no	yes
Itchy eyes	no	yes
Ear fullness	no	yes
Sinus congestion	no	yes
Stuffy nose	no	yes
Anosmia (not perceiving smell)	no	yes
Immunizations: Current?	no	Yes

4. EARS/NOSE/THROAT

Hearing loss or ringing	no	yes
Earaches or drainage	no	yes
Puffing on ears R/L	no	yes
Chronic sinus problem or rhinitis	no	yes
Nose bleeds	no	yes
Mouth sore	no	yes
Bleeding gums	no	yes
Bad breath or taste	no	yes
Sore throat or voice change	no	yes
Swollen glands in neck	no	yes
Runny nose/congestion	no	yes
Sinus pressure/drainage	no	yes
Hearing well	no	yes

5. CARDIOLOGY

Heart trouble	no yes
Chest pain or angina pectoris	no yes
Palpitations	no yes
Shortness of breath w/walking or lying flat	no yes
Swelling of feet/ankles/face	no yes
Dizziness	no yes

6.RESPIRATORY

Chronic or frequent cough	no	yes
Spitting up blood	no	yes
Shortness of breath	no	yes
Wheezing	no	yes

7.GASTROENTEROLOGY

Loss or appetite	no	yes
Change in bowel movements	no	yes
Nausea or vomiting	no	yes
Frequent diarrhea	no	yes
Painful. bowel movements or constipation	no	yes
Rectal bleeding or blood in stool	no	yes
Abdominal pain	no	Yes

8. GENITOURINARY

Cries while urinating	no	yes
Frequent urination	no	yes
Decreased urination	no	yes
Burning or painful urination	no	yes
Blood in urine	no	yes
Change force of stream urinating	no	yes
Incontinence or dribbling	no	yes
Kidney stones	no	yes
Recurrent UTI	no	yes
Sexual difficulty	no	yes
Male - testicle pain	no	yes
Male - difficulty with ejaculation	no	yes
Male difficulty with erection	no	yes
Male - diminished sex drive	no	yes

Patient's name: ______________________________________

9. INTEGUMENTARY(Skin/B

Diaper rash	no	yes
Change in skin color	no	yes
Change in hair or nails	no	yes
Varicose veins	no	yes
Breast pain	no	yes
Breast lump	no	yes
Breast discharge	no	yes

10.ENDOCRINOLOGY

Glandular or hormone problem	no	yes
Excessive thirst or urination	no	yes
Excessive sweating	no	yes
Heat or cold intolerance	no	yes
Skin becoming dryer	no	yes
Change in hat or glove size	no	yes
Sleep disturbance	no	yes

11. HEMATOLOGY

Slow to heal after cuts	no	yes
Bleeding or bruising tendency	no	yes
Anemia	no	yes
Phlebitis	no	yes
Past transfusion	no	yes
Enlarged glands	no	yes

12. MUSCULOSKELETAL

Joint pain	no	yes
Joint stiffness or swelling	no	yes
Weakness of muscles or joints	no	yes
Muscle pain or cramps	no	yes
Back pain	no	yes
Cold extremities	no	yes
Difficulty in walking	no	yes

13.NEUROLOGY

Frequent or recurring headaches	no	yes
Light-headed or dizzy	no	yes
Convulsions or seizures	no	yes
Numbness or tingling sensations	no	yes
Tremors	no	yes
Paralysis/weakness	no	yes
Head injury	no	yes
Memory loss or confusion	no	yes
Nervousness	no	yes
Depression	no	yes
Insomnia	no	yes
Sleep disturbances	no	yes
Suicidal ideation/attempt	no	yes
Eating disorder	no	yes
Excessive anxiety or worry	no	yes
Find it difficult to control the worry	no	yes
Restless, feeling keyed up or on edge	no	yes
Easily fatigued	no	yes
Difficulty concentrating or mind going Blank	no	yes
Irritable	no	yes
Muscle tension	no	yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in medical status. I also authorize the healthcare staff to perform the necessary treatment and services I may need which may include but are not limited to, laboratory procedures, x-ray examinations, diagnostic procedures, or medical or nursing treatments rendered to me under the general and special instructions of my physician.

This consent includes testing for blood-borne infectious diseases, including but not limited to hepatitis acquired immune deficiency syndrome (AIDS), and human immunodeficiency virus (HIV), if the physician orders such tests for diagnostic purposes.

Please initial: AGREE _______DISAGREE ________

Signature of patient/parent/guardian: _____________________ Date: ______

Patient's name: ____

Frisco Urgent Care & Clinics

Consent for Medical Treatment

I, the undersigned, consent to the treatment and services which may include, but are not limited to, laboratory procedures, x-ray examinations, diagnostic procedures, or medical or nursing treatments rendered to me under the general and special instructions of my physician.

This consent includes testing for blood-borne infectious diseases, including but not limited to hepatitis acquired immune deficiency syndrome (AIDS), and human immunodeficiency virus (HIV), if the physician orders such tests for diagnostic purposes.

Please initial: AGREE ________DISAGREE ___________________

Patient/Parent/Guardian Signature: ____ Date: ________________________

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient or Personal Representative: ____

Date: ______________________________

Name of Patient or Personal Representative: ____

Description of Personal Representative's Authority: ____

Signature Page for the Financial Policy

Co-signature: If this Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date: Once you have signed this agreement acknowledging **a** copy **of** the Frisco Urgent Care & Clinic's Financial Policy was given to you, you agree to **all** of the terms and conditions contained therein and the agreement will be in full force and effect.

Patient's Name: _______________________________________

Responsible party (If not the patient):

Guarantor's Signature: ________________________________ Date: _____________________

Co-Signature: Date: