PRIMARY CARE WALK-IN MEDICAL CLINIC

16605 E PALISADES BLVD, SUITE 150 FOUNTAIN HILLS, AZ 85268
2721 S. SANTAN VILLAGE PARKWAY BUILDING 1, SUITE 104 GILBERT, AZ 85295

PATIENT REGISTRATION FORM

TODAY'S DATE: _____ ☐ Married ☐ Single ☐ Divorce ☐ Widowed ☐ Female ☐ Male

PATIENTS NAME: _____ Date of Birth: _____/_____/_____ Age: _____ ☐

Home # (_____) _____-_____ Cell # (_____) _____-_____ Work # (_____) _____-_____

Address: _____ City: _____ State: _____ Zip: _____

Temp Address: _____ City: _____ State: _____ Zip: _____

E-Mail Address: _____ Social Security #_____

Emergency Contact Name: _____ Phone # _____

Can we leave a message at your #? ☐ Yes ☐ No If Yes – then which phone # (_____) _____-_____

Do you authorize the office staff to discuss your care of treatment with any other parties other than yourself?
☐ Yes ☐ No If Yes – then whom? _____ Relationship _____

RACE_____ETHNICITY_____REFUSE TO REPORT ☐

***PHARMACY** _____ **ADDRESS** _____ **PHONE #**_____

*****PLEASE FILL BELOW IF INSURANCE IS UNDER SPOUSE OR PARENT. *****

PRIMARY Insurance Co: _____	SECONDARY Insurance Co: _____
Insured Name:_____	Insured Name:_____
Insured SS# _____ -____-_____ D.O.B. _____/_____/_____	Insured SS# _____ -____-_____ D.O.B. _____/_____/_____
Relationship to Patient: _____	Relationship to Patient: _____
Policy #_____ Group #_____	Policy #_____ Group #_____

RELEASE AND ASSIGNMENT

I, the undersigned have insurance coverage with _____ and assigned directly to ***Primary Care Walk-In Medical Clinic, LLC*** all medical benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by said insurance, unless assignee has executed an agreement with my insurance provider or plan. I understand that is such agreement has been executed; I may be responsible to pay any deductible and/or co-payment (%) and non-covered services under the terms of my insurance. I understand that any payments, which are due, starting 30 days after insurance coverage has been completed, will be charged a $3.00 monthly late service charge: (or) at a rate pf 1.5% interest per month on unpaid balance, whichever is larger. I understand that I am financially liable in the event of non-payment: I agree to pay the collections agency's cost and/or court cost and reasonable attorney fees. ***Payment of co-pays, % are due at time of service. Patient with no insurance coverage, payment is due at time of service. We accept, cash, Visa, MasterCard, Discover, American Express. $40 charge for any returned checks.***

Signature of Patient/Guardian: _____ Date: _____

I request that payment of authorized **Medicare** benefits to be made directly to: ***Primary Care Walk-In Medical Clinic, LLC*** on my behalf for any service furnished by the physician, I authorize any holder of medical information about me release to CMS and its agents needed to determine these benefits payable for related services. I understand that a signature request may be made to authorize the release of medical information necessary to pay a claim. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as full charge, and the patient is responsible for full deductible, co-insurance services. Co-insurance and deductible are based upon the charge determination of the Medicare carrier.

Signature: (MEDICARE) _____ Date: _____

Patient Name: _____ **Date of Birth:** _____

1. Reason for your visit: (please explain your current problem in your own words)

_____

2. Does any of the medical problems apply to you?

Heart disease, High blood pressure, Stroke, Asthma, High Cholesterol,

Diabetes, Hepatitis, HIV, Thyroid Disease, or any other _____.

3. Do you have any of these symptoms?

Fever	Weight Gain	Shortness of Breath	Pain in the Belly	Blood in stools Dark stools
Cough	Weight Loss	Chest pain	Diarrhea	Nausea or vomiting
Sore Throat	Mood Changes	Back pain	Constipation	Numbness or tingling

4 .Have you had any Surgery?

_____

5. Please List all your Medications and Dosage:

5. **Allergies** to any environmental agents or medications: _____

6. Do you have **advance directives** in place _____

7. Social history (past or present)

Do you smoke?	Yes	no	if yes how much?	Per Day
Do you drink Alcohol?	Yes	no	if yes how much?	Per Day
Any drug use?	Yes	no	what kind?	_____

8. Family Medical History: please list any close relatives that have the following:

Heart disease	Hypertension	Cancer	Asthma	High Cholesterol	Stroke	Diabetes	Other

9. Any recent travel out of the country or any plans to travel out of country in the next 6 months?

_____

10. How did you hear about us?

Medical Information Release Form

(HIPAA Release Form)

Name: _____ **Date of Birth:** ____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Children_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____ If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*) _____ between (*time*) _____

Signed: _____ Date: ____/____/_____