

# Patient Information

## EZCare Walk-In Medical Center

Thank you for choosing our EZCare. In order to serve you properly, we need the following information.

**(PLEASE PRINT)**. All information will remain confidential.

### **PATIENT INFORMATION:**

Today's Date: \_\_\_\_\_ / \_\_\_\_\_ / 201\_\_

Patient Name: Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

DOB: \_\_\_ / \_\_\_ / \_\_\_ check one:  Married  Single  Separated  Divorced  Widowed  Other

Social Security #: \_\_\_\_\_  Male  Female

Responsible Party (If minor child) Name: \_\_\_\_\_

Address: \_\_\_\_\_

DOB: \_\_\_ / \_\_\_ / \_\_\_ Social Security #: \_\_\_\_\_ Phone: \_\_\_\_\_

### **Primary Insurance:**

Insurance Name: \_\_\_\_\_ Policy # \_\_\_\_\_

Policyholder's Full Name: \_\_\_\_\_ Policyholder's Address: \_\_\_\_\_

DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ SSN: \_\_\_\_\_ Relationship: \_\_\_\_\_

### **Secondary Insurance:**

Insurance Name: \_\_\_\_\_ Policy # \_\_\_\_\_

Policyholder's Full Name: \_\_\_\_\_ Policyholder's Address: \_\_\_\_\_

DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ SSN: \_\_\_\_\_ Relationship: \_\_\_\_\_

### **Emergency Contact Information:**

Emergency Contact Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

How did you hear of us?  Newspaper  Radio  Billboard  TV  Friend  Website  Other \_\_\_\_\_

Reason for visit: \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Location: \_\_\_\_\_

**ALLERGIES:** \_\_\_\_\_

I authorize treatment for myself/my child based on the information I have provided regarding my past/current medical conditions. I also authorize the release, based on HIPAA privacy Act, of any medical information concerning myself/my child healthcare, advice and treatment (medical care) provided only for the purpose evaluating/administering claims for insurance benefits/or continuity of care. I hereby authorize payment of insurance directly to the Provider. I also acknowledge billing my insurance is not a guarantee of payment and I am responsible for any amount not covered by my insurance company. I also release information to my employer concerning Workers Compensation Injury. Insurance deductibles and co-pays are due at the time of service.

**Signature of Patient/Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_ / \_\_\_\_\_ / 201\_\_



## Health History Questionnaire

(Please Complete ALL Information Requested)

Patient Name: \_\_\_\_\_

Chief Complaint: Describe your major symptoms or reason for your visit today:

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If female, are you pregnant now:  Yes  No

Are you planning to get pregnant soon:  Yes  No

**PAST MEDICAL HISTORY:**

<input type="checkbox"/> Gastrointestinal	<input type="checkbox"/> Anemia	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Mumps	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/> Asthma
<input type="checkbox"/> Chicken Pox or Measles	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Sexually Transmitted Infection
<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> AIDS or HIV	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Back Trouble	<input type="checkbox"/> Stroke

Other: \_\_\_\_\_

**PAST SOCIAL HISTORY:**

Alcohol Use:     \_\_ Never \_\_ Rarely \_\_ Moderately \_\_ Daily

Tobacco Use:    \_\_ Daily \_\_ How many packs? \_\_ Quit Date \_\_ Age Started \_\_ Never

**Current Medications: List all medications you are currently taking:**

**Medication/Dose**


**Allergies to Medications: List all allergies and the kind of reaction.**


**Previous Hospitalizations/Surgeries/Serious Illnesses:**

Description	Date	Hospital, City, State



## PATIENT ACKNOWLEDGE OF NOTICE OF PRIVACY PRACTICES

Patient Name: \_\_\_\_\_

I, \_\_\_\_\_ acknowledge that I am aware of EZCare Walk-In Medical Center Notice of Privacy Practices. I acknowledge that I have received or have been offered (upon request) a copy of the Privacy Practices and Communications Consent. Copies are posted in the clinic lobby and printed copies are available upon request at the reception desk.

### CONTACT INFORMATION

(Please circle one for each question)

May we call you at home phone?  YES  NO Work?  YES  NO

May we call you on your cell phone?  YES  NO Work?  YES  NO

May we leave a message at home/cell?  YES  NO Work?  YES  NO

May we discuss your health information with:

Spouse?  YES (name) \_\_\_\_\_  NO \_\_\_\_\_

Parent?  YES (name) \_\_\_\_\_  NO \_\_\_\_\_

Other?  YES (name) \_\_\_\_\_ (relationship) \_\_\_\_\_

Your health information may consist of items such as diagnosis, treatments, labs, prescriptions and appointments.

\_\_\_\_\_ Date: \_\_\_\_\_

Signature of Patient, Parent or Guardian



## Acknowledgement of Receipt of Notices of Privacy Practices

Patient Name: \_\_\_\_\_

I, \_\_\_\_\_ have received a copy of this Office's Notice of Privacy Practices.

\_\_\_\_\_  
Name of Patient (Print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledge could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify) \_\_\_\_\_