EZCARE
WALK-IN MEDICAL CENTER

PATIENT INFORMATION

PATIENT NAME: LAST_____ FIRST _____ M _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

BIRTHDAY: _____/_____/_____ SOCIAL SECURITY #: _____-_____-_____ M_____F _____

EMAIL ADDRESS: _____

EMERGENCY CONTACT NAME: _____

RELATIONSHIP: _____ PHONE: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ POLICY #_____

POLICY HOLDERS FULL NAME: _____ RELATIONSHIP _____

ADDRESS (IF DIFFERENT THAN ABOVE) _____

BIRTHDAY: _____/_____/_____ SOCIAL SECURITY #: _____-_____-_____ M_____F _____

SECONDARY INSURANCE: _____ POLICY # _____

POLICY HOLDERS FULL NAME: _____ RELATIONSHIP _____

ADDRESS (IF DIFFERENT THAN ABOVE) _____

BIRTHDAY: _____/_____/_____ SOCIAL SECURITY #: _____-_____-_____ M_____F _____

FOR CHILDREN UNDER 18

RESPONSIBLE PARTY FULL NAME: _____
(This is the person who is filling out the paperwork today)

ADDRESS (IF DIFFERENT THAN ABOVE) _____

BIRTHDAY: _____/_____/_____ SOCIAL SECURITY #: _____-_____-_____ M_____F _____

PHONE: _____ RELATIONSHIP: _____

How did you hear about us? _____ Preferred Pharmacy: _____

Reason for visit: _____

HEALTH HISTORY QUESTIONNAIRE

(PLEASE COMPLETE ALL INFORMATION)

PATIENT NAME: _____ DOB: _____

(**Female**: Are you pregnant now? ___ yes ___ no Last Menstrual Cycle: _____)

MEDICAL HISTORY:

___ Anemia/Blood Disease
___ Bladder Disease
___ Bleeding Tendency
___ Blood Clots
___ Cancer (past or present)
___ Cervical Spine Disorder
___ Chronic Skin Disease
___ Depression
___ Diabetes
___ Heart Disease
___ High Blood Pressure
___ High Cholesterol
___ Hypoglycemia (Low Glucose)
___ Joint Replacement
___ Kidney Disease
___ Liver Disease
___ Lumbar Spine Disorder
___ Lung Disease
___ Mental Health Problems
___ Muscle Disease
___ Nerve Impairment
___ Prostate Disease
___ Seizures
___ Severe Headaches
___ Sleep Apnea
___ Stomach Disease
___ Stroke
___ Thyroid Disease
___ Tuberculosis/TB
___ Other_____

PERSONAL HABITS

Do you drink caffeinated beverages (coffee, tea, soda)? _____ If yes, daily intake? _____
Do you drink alcoholic beverages? ……. _____ if yes, how much?
_____
Do you smoke or chew tobacco? ……. _____ if yes, _____ per day

CURRENT MEDICATIONS: _____
_____
_____
_____

ALLERGIES TO MEDICATIONS AND REACTION: _____
_____
_____
_____

ALL PREVIOUS SURGERIES: _____
_____
_____
_____

FAMILY HISTORY:

Father? __ Alzheimer's/Dementia __ Asthma __Cancer __ Cholesterol __ Diabetes __ Heart Disease __ High Blood Pressure __ Other _____
Mother? __ Alzheimer's/Dementia __ Asthma __Cancer __ Cholesterol __ Diabetes __ Heart Disease __ High Blood Pressure __ Other _____
Grandparents? __ Alzheimer's/Dementia __ Asthma __Cancer __ Cholesterol __ Diabetes __ Heart Disease __ High Blood Pressure __ Other _____

PATIENT ACKNOWLEDGE OF NOTICE OF PRIVACY PRACTICES

Who may we discuss your health information with? Your health information may consist of items such as diagnosis, treatments, labs, prescriptions, and appointments.

Spouse? ___ NO ___ YES Name _____ Phone: _____

Parent? ___ NO ___ YES Name _____ Phone: _____

Other? ___ NO ___ YES Name _____ Phone: _____

****WE WILL ONLY DISCUSS YOUR HEALTH INFORMATION WITH THE PEOPLE LISTED ABOVE****

1. I, _____ acknowledge that I am aware of Ezcare Walk-In Medical Center's 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.
2. 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's healthcare, advice, and treatment (medical care) provided only for the purpose of evaluating/administering claims for insurance benefits/or continuity of care. I hereby authorize payment of insurance directly to the provider. I also authorize the release of information to my employer concerning claims related to a Workers Compensation injury.
3. I understand billing my insurance is not a guarantee of payment, and I am responsible for any amount not covered by my insurance company.
4. I understand that Insurance co-pays and deductibles are due at the time of service.

_____
Name of patient (print)

_____ Date: _____
Signature of patient (or parent/Guardian)