QUALITY URGENT CARE & WELLNESS

GENERAL PATIENT INFORMATION

Last Name: _____ First Name: _____MI:_____ Suffix: _____
Date of Birth: _____ Sex: □ M □ F SSN: _____Email:_____
Address:_____Apt#:_____City:_____State:_____Zip code:_____
Contact Number _____Preferred Language: _____ **Do you need an interpreter □Y □N**
Race/Ethnicity: □ African American/Black □ Asian □ Caucasian/White □ Hispanic/Latino □ Other: _____
Primary Care Physician: _____ *PCP Phone #:*_____

Responsible Party/Guarantor for Minor Patient's

Last Name: _____ First Name: _____ MI: _____Suffix: _____
Date of Birth: __ __ (MM) __ __ (DD) __ __ __ __(YYYY) Sex: □ M □ F SSN: _____
Relationship to Patient: _____ Contact Number _____
Address: _____Apt#:_____City:_____ State:_____Zip code:_____
Emergency Contact: Last Name: _____ First Name: _____
Relationship to Patient: _____ Home #: _____Cell #: _____

☐Self Pay ☐Primary Insurance:_____ ☐Secondary Insurance:_____

Primary Info: Policyholder Name: _____ Relationship _____ DOB: _____
Sex: _____SS: _____
Secondary Info: Policyholder Name: _____ Relationship _____ DOB: _____
Sex: _____SS: _____

CONSENT TO MEDICAL TREATMENT, PAYMENT and HIPAA PRIVACY

Consent for Treatment: I understand that there are inherent risks and dangers associated with treatment through an Urgent Care Setting and assume responsibility for being seen or having my dependent/child seen and treated by QUCW staff members. I hereby waive, release, and discharge all claims of damage, personal injury, or personal illness against QUCW because of being seen in this setting. This release is intended to indemnify and hold harmless QUCW and its staff members from all liability related to potential hazardous community exposure. I understand that QUCW treats conditions like Covid-19, Influenza, Streptococcus, Scabies, and Head Lice, and although risk for exposure is low, there still is a risk presenting when being treated in an urgent care setting. I consent to medical treatment for myself or minor child. I understand that an examination and treatment I receive is not intended to replace a primary care assessment, but instead to supplement in times of acute need. I understand that QUCW is not a primary care physician. I also understand that I should include in this intake form my medical history including but not limited to current medications and current medical conditions. I finally understand that QUCW may not be able to see me if I present with the same issue 3 times consecutively in a 6-month period or 4 times per year for the same issue. I agree to the Notice of Privacy Practices that can be provided per my request. I agree to have information, results, or excuses sent to a non-secure email that I have written above at my request.
Consent for Payment: recognize that by signing this agreement, it is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid. It is also my responsibility to present every visit with my ID and, if applicable, my most up to date insurance card information to avoid additional costs by previous and current insurance companies. If I am without insurance and self-paying, I understand that I must pay the 125.00 fee to initially be seen. I am also responsible for paying for any procedures, medications or supplies discussed with the provider upon discharge. I recognize and accept responsibility for services rendered regardless of insurance coverage. I understand that payment is due before service. I also understand that my insurance may not cover my entire visit and will require payment before my next assessment. I recognize that QUCW does not provide refills for controlled substances and can only provide a 1-time prescription refill for medications I am currently taking or recently have run out of. I am aware that QUCW may not be able to fill all my prescriptions if I present for refills and I will need to present with prescription bottles or pharmacy print out for review.
Consent for Procedures/Xray/Send out Labs: I recognize that by signing below I give clinical consent for myself or my minor to have an Xray, Laboratory Testing, or Pelvic Examination. If having an X-ray procedure, I report no risk of pregnancy. If send out laboratory testing is required through my contracted insurance lab (Quest or LabCorp) and assume responsibility of any costs for send out testing. Finally, I understand that if my condition requires evaluation of the groin/privates that I give consent for assessment and evaluation.
Consent for Release of Information I authorize Quality Urgent Care & Wellness, to disclose my medical information & other protected health information to the following persons, physician, or hospital. **If no one is listed, no information will be released**

AUTHORIZED (Person, Business, or Doctor)	RELATIONSHP	Personal ID NEED TO ACCESS RECORDS Example: Can use their DOB, Address or 4 of SSN

Patient Signature/Guardian Signature: _____ Date: _____

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CHIEF COMPLAINT

LIST SYMPTOMS: **HOW MANY DAYS:**

ALLERGY LIST

DO YOU HAVE FOOD, ENVIRONMENTAL OR MEDICATION ALLERGIES? ☐Yes ☐No

If YES, please list: _____

PHARMACY

LOCAL PHARMACY: ☐ Walgreens ☐ Walmart ☐ CVS ☐ Publix ☐ Winn-Dixie ☐ Other _____

Local Pharmacy Zip code or Address_____

MEDICATIONS

LIST ANY PRESCRIBED OR OVER THE COUNTER THERAPY BELOW OR PROVIDE A LIST TO OUR STAFF

IF NO MEDICATIONS MARK: ☐ None

Medication	Taking For	Medication	Taking For
1		4	
2		5	
3		6	

PATIENT AND FAMILY HISTORY

DO YOU HAVE ANY HISTORY OF HEALTH CONDITIONS/MEDICAL PROBLEMS ☐Yes ☐No

DOES YOUR IMMEDIATE FAMILY HAVE ANY HISTORY OF HEALTH CONDITIONS/MEDICAL PROBLEMS ☐Yes ☐No

If YES, please check ☑ any medical problem(s) you or your family currently have

	Patient	Mother	Father	Sister	Brother		Patient	Mother	Father	Sister	Brother
Anxiety (F41.9)						Fibromyalgia (M79.7)					
Anemia (D64.9)						GERD (K21.9)					
ADD/ADHD (F90.0)						Headache (G43.909)					
Arthritis (M13.88)						Heart Disease (I51.9)					
Asthma (J45.909)						Hepatitis (K73.9)					
Bipolar (F31.9)						HIV/AIDS (B20)					
Cancer (C80.1)						Hyperlipidemia (E78.5)					
Chronic Pain (G89.4)						Hypertension (I10)					
COPD (J44.9)						Hypothyroidism (E03.9)					
CVA-Stroke (I63.9)						IBS (K58.9)					
Depression (F32.9)						Insomnia (G47.00)					
Diabetes II (E11.9)						Kidney Disease (N18.9)					

OTHER PATIENT PROBLEMS:

FAMILY ALIVE? MOTHER ☐Yes ☐No ☐N/A **FATHER** ☐Yes ☐No ☐N/A **BROTHER** ☐Yes ☐No ☐N/A **SISTER** ☐Yes ☐No ☐N/A

SURGICAL HISTORY

HAVE YOU HAD ANY SURGERIES: ☐Yes ☐No . If Yes, please list Surgery and Date

Surgery Name	Date			Surgery Name	Date		
1.				4.			
2.				5.			
3.				6.			

SOCIAL HISTORY

Smoker ☐Yes ☐No *If yes, packs/week* ____ **Chew/Dip** ☐Yes ☐No *If yes cans/week*___ **Former Smoker** ☐Yes ☐No

Vape ☐Yes ☐No *If yes, How many cartage/week* _____ **Alcohol** ☐Yes ☐No *If yes drinks/week*_____

Caffeine Intake ☐Yes ☐No *If yes drinks/day*_____ **Exercise** ☐Yes ☐No *If yes: Minutes* _____ *x per week*_____

PREGNANT ☐Yes ☐No ☐N/A, If Yes how far along _____ weeks. **Breastfeeding** ☐Yes ☐No ☐N/A