OFFICE USE ONLY: NEW PT / EST PT / PCP PT

PRIVATE / WORKER'S COMP / EPS / AUTO

DATE OF SERVICE: _____

TIME REC'D: _____

Central Urgent Medical Care

9695 BASELINE RD.
RANCHO CUCAMONGA, CA. 91730
PH 909-941-0920 / FAX 909-941-0940

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI: ____

DATE OF BIRTH: / / GENDER: MALE ☐ FEMALE ☐ SOCIAL SECURITY NUMBER: ___-___-____

AGE: _____ HEIGHT: _____ WEIGHT: _____

MARITAL STATUS: SINGLE ☐ MARRIED ☐ DIVORCED ☐ OTHER ☐ PREFERRED LANGUAGE: *ENGLISH* ☐ *SPANISH* ☐ *OTHER* ☐

EMAIL: _____ RACE: _____ ETHNICITY: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ PREFFERED PHONE: HOME ☐ CELL ☐

PRIMARY CARE PHYSICIAN: _____ PHN#: _____

PREFERRED PHARMACY: _____

PHARMACY ADDRESS (CROSS STREETS): _____

GUARANTOR INFORMATION (*PLEASE COMPLETE THIS SECTION IF THE PATIENT IS UNDER 18*)

CONTACT NAME: _____ RELATIONSHIP TO PATIENT: _____

D.O.B.: _____ SOCIAL SECURITY#: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PRIMARY PHONE: _____ WORK PHONE: _____

EMPLOYER INFORMATION

EMPLOYER NAME: _____ EMPLOYER PHONE: _____

EMPLOYER ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

INSURANCE

PRIMARY INSURED ID #: _____ INSURANCE NAME: _____

SECONDARY INS ID #: _____ SECONDARY INS NAME: _____

OFFICE USE ONLY:

PAID COPAY (AMT): _____

CASH / CHECK / AMEX / MC / VISA / OTHER

MA INITIALS: _____

SCANNED

INSURANCE VERIFIED BY PHONE:

Central Urgent Medical Care

Medical Practice
Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I am aware of Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Central Urgent Medical Care health care operations. The Notice of Privacy Practices also describes my rights and Central Urgent Medical Care's duties with respect to my protected health information. The Notice of Privacy Practices is posted in 9695 Baseline Rd. Rancho Cucamonga, CA 91730.

Central Urgent Medical Care Rancho reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain the notice or a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, asking for one at the time of my next appointment.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

CONSENT FOR TREATMENT/MEDICAL RELEASE AUTHORIZATION

PRINT PATIENTS NAME x_____Date_____

I, the undersigned, hereby authorize CENTRAL URGENT MEDICAL CARE and whoever they designate as their assistants to perform diagnostic test, including but not limited to radiographs, and administer treatment as is necessary. I also certify that no guarantee or assurance has been made to the results that may be obtained. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid to his account. I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPOSIBLE FOR PAYMENT.I UNDERSTAND THAT CENTRAL URGENT MEDICAL CARE WILL VERIFY INSURANCE COVERAGE BUT THIS IS NOT A GUARANTEE OF PAYMENT OR HOW MY INSURANCE COMPANY WILL PROCESS MY TYPE OF INSURNACE COVERAGE I HAVE.

Patient's signature x_____Date_____

AUTHORIZION TO RELEASE MEDICAL INFORMATION
I authorize the release of any medical information necessary to process my insurance claim and certify that all insurance information given to this clinic is correct and complete.

Patient's signature x_____Date_____

REQUEST FOR PAYMENT OF BENEFITS TO PROVIDER OF CARE
I hereby authorize my primary/secondary insurance company admin to pay by check, and for it to be mailed directly to CENTRAL URGENT MEDICAL CARE the expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said applicable charges. I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill.

Patient's signature x_____Date_____

CONSENT FOR TREATMENT OF MINOR
I hereby authorize CENTRAL URGENT MEDICAL CARE and whomever they may designate as their assistant to perform diagnostic test, including but not limited to radiographs, and to administer treatment as he deems necessary to my child.

Patient's signature x_____Date_____

SELF PAY / NO INSURANCE FINANCIAL POLICY
Office Visit - Consultation fee does not include treatment. Treatment / In Office Procedures - Any type of order that is requested by the Physician is rendered at an additional fee and must be paid in full at the time of service. Example of this (but not limited to) would be: XRAYS, THERAPEUTIC INJECTION (ANTIBIOTIC), URINALYSIS, SUTURES, LABS OR SPLINTS. (*this service is NOT included in routine medical visit fees – this is considered an "in-office" procedure and will be billed accordingly.) Patients will be held completely responsible for all accrued charges and account balances regarding all services rendered by CENTRAL URGENT MEDICAL CARE.

Patient's signature x_____Date_____

X RAY/MEDICAL RECORDS RELEASE
I have requested the release of records of (Patient's name) _____ which are a part of the records at facility_____. I hereby request and authorize you, your employees and agents to furnish to the person listed below or anyone designated in writing by them.2 copies of records including copies of x-rays and photo static copies, abstracts or excerpts of all records and any other information they may request relating to any examination treatment or opinion concerning any condition that I may have in the past, now have, or may have in the future. Please forward this to CENTRAL URGENT MEDICAL CARE RANCHO 9695 BASELINE RD. RANCHO CUCAMONGA, CA 91730.

Patient's signature x_____Date_____

ATTORNEY REPRESENTATION AND PROTECTION OF BALANCE
I the undersigned patient am directing my attorney, to pay any outstanding bills of my settlement and, in effect, protecting any such balance. I hereby make and declare the instructions herein contain to be irrevocable. I fully understand that I am directly responsible for all medical bills and this agreement is made solely for the doctor's additional protection and consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judge or verdict by which I may eventually recover said fee. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but will require me to make payment on a current status.

Patient's signature x_____Date_____

PATIENT'S NAME: _____ CHART UP/FRONT DESK: _____

CHART UP FOR PROVIDER: _____

PT DOB: _____ **PT ID #** _____

PROVIDER: TN-MD / DL-PA/ KM-PA / MC-NP/ SM-PA/ BN-NP/JC -NP

WHAT ARE WE SEEING YOU FOR TODAY? Please be specific: _____

_____

WHEN DID THIS START? _____

MEDICAL HISTORY

Do you have **ANY** health conditions **(under control or not)** either chronic or inactive **(Check all that apply)**

Did your check your sugar today?

☐ Arthritis	☐ Blood Disorders	☐ Cancer	☐ Diabetes _____ mg/dl
☐ Gastrointestinal	☐ Heart Problems	☐ High Blood Pressure	☐ Cholesterol
☐ Kidney Problems	☐ Liver Problems	☐ Lung Problems	☐ Neurological
☐ Stroke, Seizures	☐ Prostate	☐ Psychiatric	☐ Skin Disorders
☐ STD's	☐ Thyroid	☐ **NO CONDITIONS**	☐ Other _____

When was your last Physical? (DATE)_____ Last Blood Draw? (DATE)_____ STD Screen > 13 years of age? (DATE) _____

(FEMALES) When was your last Mammogram >40 years of age?..... (DATE) _____

(FEMALES) Last Pap Smear >21 years old or earlier if sexually active?..... (DATE) _____

If you are >50 years of age when was your last Colonoscopy?..... (DATE) _____

When was your last Bone Scan? (DATE) >60 year old female_____ >70 year old male_____ >55 year old female or male with Diabetes or thyroid problems_____

SURGERIES: Have you had ANY surgeries? ☐ YES ☐ NO

If YES, what kind and when? (PLEASE CHECK) ☐ Appendectomy ☐ Hysterectomy ☐ Breast Aug ☐ Cyst ☐ Tonsillectomy

Other Surgery type (please explain): _____

FAMILY HISTORY:

Do the patient's parents, siblings or grandparents have any health conditions? If YES, who has it and what do they have?

BROTHER_____ SISTER:_____ MOTHER:_____ FATHER:_____ GRANDPARENTS:_____ (OR) ☐ NO FAMILY HISTORY

SOCIAL HISTORY:

Do you drink, smoke, or use illegal drugs or medical marijuana? If yes, list what and how much, how often?

DRINK:	SMOKE:	DRUGS:
☐ NEVER ☐ 3 TIMES A WEEK ☐ DAILY ☐ OCCASIONALLY ☐ SOCIALLY ☐ MODERATELY	☐ NEVER ☐ SOCIALY ☐ FORMER SMOKE ☐ WEEKENDS ☐ DAILY A DAY: (select one from below) 1-5 CIG ◯ 6-10 CIG ◯ ½ PACK ◯ 1PK ◯ 11/2 PK ◯	DO YOU USE DRUGS? ☐ YES ☐ NO DO YOU USE MARIJUANA? ☐ YES ☐ NO

IMMUNIZATIONS / TETANUS:

When was your Last Flu Shot? (DATE) _____

When was the last Pneumovax Vaccine if >65 years of age or >55 years of age with diabetes or hypertension? (DATE) _____

Immunizations are? ☐ Up To Date ☐ NOT Up To Date

Is your Tetanus current within 10 years? ☐ Up To Date Within the Last 10 Years ☐ NOT Up To Date

ALLERGIES TO MEDICATIONS:

☐ **NO KNOWN DRUG ALLERGIES**

Allergy To:_____ Type of Reaction: ☐ RASH ☐ SHORTNESS OF BREATH ☐ THROAT SWELLS ☐ CHILDHOOD REACTION

Allergy To: _____ Type of Reaction: ☐ RASH ☐ SHORTNESS OF BREATH ☐ THROAT SWELLS ☐ CHILDHOOD REACTION

Are you currently taking any medications either prescription or over the counter? If so what, how much, and how often?

Blood Pressure: _____ Diabetes Med: _____

Others: _____ ☐ **NO MEDICATIONS**

Do you have any of the following symptoms TODAY? (PLEASE CIRCLE THE ONES THAT APPLY)

CONSTITUTION:	FEVER ☐	CHILLS ☐	SWEATS ☐	FATIGUE ☐	WEIGHT LOSS ☐	**NONE** ☐
HEAD:	EARS ☐	MOUTH ☐	TOOTH ☐	THROAT ☐	HEADACHE ☐	**NONE** ☐
EYES:	BLURRED VISION ☐	DOUBLE VISION ☐	EYE PAIN ☐	EYE DISCHARGE (LIKE MUCUS) ☐		**NONE** ☐
CARDIO:	CHEST PAIN/PRESSURE ☐ (TO COUGH?)	LIGHTHEADED	FAINTING ☐	FLUTTERING / PALPITATIONS ☐		**NONE** ☐
RESPIRATORY:	SHORTNESS OF BREATH ☐	COUGH (DATE STARTED_____) ☐	WHEEZING ☐			**NONE** ☐
GI:	STOMACH PAIN (DUE TO COUGH?) ☐	DIARRHEA ☐	NAUSEA ☐	VOMITING (DUE TO COUGH) ☐		**NONE** ☐
GU:	PAINFULL URINATION ☐	FREQUENT URINATION ☐	WAKING TO URINATE ☐	ITCHING ☐	DISCHARGE ☐	**NONE** ☐
MUSCULAR:	MUSCLE PAIN ☐	JOINT PAINS ☐				**NONE** ☐
SKIN:	RASH ☐	ITCHING ☐	BITES ☐	SKIN SORES ☐	REDNESS ☐	**NONE** ☐
NEUROLOGICAL:	DIZZINESS ☐	WEAKNESS ☐	POOR BALANCE ☐	NUMBNESS ☐	TINGLING ☐	**NONE** ☐
PSYCHIATRIC:	DEPRESSION ☐	ANXIETY / NERVES ☐	DIFFICULTY SLEEPING ☐			**NONE** ☐
ALLERGY:	ITCHY EYES ☐	SNEEZING ☐	RUNNY NOSE ☐			**NONE** ☐

OFFICE USE ONLY

HEIGHT: _____ _____

WEIGHT: _____ _____

BMI: _____ _____

B/P: _____ _____

TEMP: _____ _____

PULSE: _____ _____

RESP: _____ _____

GLUC: _____ _____

POX: _____ _____

LMP: _____ _____

SMA INITIALS: _____ _____

MA: _____ _____

MA SIGN OFF: _____ _____