Patient Central
Urgent Care • Primary Care • Heart Care

PATIENT REGISTRATION INFORMATION

PLEASE PRINT AND COMPLETE ALL SECTIONS OF THIS FORM

LAST NAME_____ FIRST NAME_____ INITIAL _____

DATE OF BIRTH _____ SEX ❑ M ❑ F SOCIAL SECURITY _____

MARITAL STATUS ❑ S ❑ M ❑ W ❑ D ❑ Other_____

ADDRESS _____ CITY_____ STATE_____ ZIP _____

HOME PHONE _____ CELL _____ EMAIL ADDRESS _____

SPOUSE NAME _____

RACE ❑ White ❑ Black ❑ Asian ❑ Native Hawaiian/Pacific Islander ❑ American Indian/Alaskan Native ❑ Hispanic ❑ Other

ETHNICITY ❑ Hispanic/Latino ❑ Non-Hispanic/Latino ❑ Unreported/Refused

LANGUAGE ❑ English ❑ Spanish ❑ French ❑ Arabic ❑ Chinese ❑ Sign Language

EMPLOYER _____ WORK PHONE _____

Responsible Party Information *(for patients under 18 and other dependent patients)*

Name:_____ Relationship to patient:_____
Last First Middle Initial

Social Sec. #:_____

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

DOB:_____ **Sex**: ❑F ❑M Phone:_____ ❑Home ❑Cell ❑Other
MM/DD/YYYY

Emergency Contact

Name:_____ Phone:_____ Relationship to patient:_____

Patient's Insurance Information

Primary Policy:_____

Policy Holder:_____

Date of Birth:_____

Relationship to Patient:_____

Secondary Policy:_____

Policy Holder: _____

Date of Birth: _____

Relationship to Patient: _____

Patient Central
Urgent Care • Primary Care • Heart Care

Patient Registration Form (Continued)

Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Patient Central. I authorize this healthcare provider to release any information necessary to ensure payment by my insurance company. I understand I am financially responsible for all charges not covered by insurance, including patient co-pay, deductible, non-covered services or vaccinations. Charges for paperwork are not covered by insurance, and will be charged a $30 fee. **I understand that my account may be turned over to collections for failure to make payments within 90 days upon receiving my statement.**

➡ _____ _____

Signature of Patient or Legal Guardian | Date

Acknowledgment of Notice of Privacy Practices

The notice of Privacy Practices was posted in a clear and prominent location where I was able to read the Notice of Privacy Practices. A copy is available to you upon request.

➡ _____ _____

Signature of Patient or Legal Guardian | Date

Notice of Narcotic Policy

I understand that Patient Central does not prescribe narcotic medications. In the event I should need this type of medication, I understand I will be referred to a specialist or pain management clinic. Patient Central does not prescribe long term pain medications. I fully accept and will comply with this policy of Patient Central.

➡ _____ _____

Signature of Patient or Legal Guardian | Date

Missed Appointments / *Same Day Cancellation Policy*

I also acknowledge I am responsible for payment of the fees listed below relating to missed appointments and same-day cancellations.
1st – No Charge
2nd - $25
3rd - $100, also may be subject to immediate discharge from our office.

By signing below, I agree to the above communication preferences, privacy practices, as well as assignment of benefits.

➡ _____ _____

Signature of Patient or Legal Guardian | Date

Patient Central
Urgent Care • Primary Care • Heart Care

Patient Name: _____ DOB: _____ Date: _____
MM/DD/YYYY

Reason for being seen today: _____

Have you had any recent international travel? ❑ Yes ❑ No

Is this a follow up visit? ❑ Yes ❑ No

Do you need medication refills? ❑ Yes ❑ No

Allergies:

Are you allergic to any medications? ❑ Yes ❑ No
If Yes, please list all.

Do you have any other allergies? ❑ Yes ❑ No
If Yes, please list all.

Medications:

Are you taking any medications, prescription or over the counter, right now? ❑ Yes ❑ No
If Yes, please list all medications.

Medication Name	Strength	Quantity taken at one time	Times per day taken

Please list any other medications on the back of this form.

Social History:

Do you use tobacco?	❑ Yes, everyday	❑ Yes, on occasion	❑ No, former user	❑ No, never
Do you drink alcohol?	❑ Yes, everyday	❑ Yes, socially	❑ No, former user	❑ No, never
Do you use illegal drugs?	❑ Yes, everyday	❑ Yes, socially	❑ No, former user	❑ No, never
Are you currently employed?	❑ Yes, full time	❑ Yes, part time	❑ No, retired	❑ No, other

Family History:

Does any of your immediate blood relatives (grandparents, parents, siblings) have any of the following conditions?

Condition	Yes	No	Relative	Condition	Yes	No	Relative
Diabetes				Osteoarthritis			
High Blood Pressure				Rheumatoid Arthritis			
Heart Disease				Heart Attack/ Murmurs			
Cancer				Thyroid Disease			
Type				High Cholesterol			
Kidney Disease				Liver Disease			
Dementia				Stroke			

Patient Central
Urgent Care • Primary Care • Heart Care

Date:_____ Name:_____ Birthdate: _____

Medical History

Do you have any current medical conditions you are being treated for? ❑ yes ❑ no Please list.

Do you have any past medical conditions you have been treated for? ❑ yes ❑ no Please list.

Surgical History

Have you ever had any surgeries? ❑ yes ❑ no Please list and specify Right or Left if applicable. (May add additional information on back of form)

Hospitalization History

Have you ever been hospitalized overnight? ❑ yes ❑ no Please list when and where as well as reason. (May add additional information on back of form)

	When:		When:
General:		**Eyes:**	
❑ Good Health Lately		❑ Eye disease or injury	
❑ Recent unexplained weight loss or gain		❑ Wear glasses or contacts	
❑ Fever/Chills/Sweats		❑ Blurred Vision/Glaucoma/Cataracts	
❑ Fatigue		❑ Flashing Lights/Floaters	
❑ Headaches		❑ Watery/Itchy/Discharge from eyes	
Ears, Nose, Throat, Mouth	When:	**Cardiovascular:**	When:
❑ Hearing loss or ringing		❑ Heart Problems	
❑ Earache or drainage		❑ Chest pain	
❑ Chronic sinus problems/head congestion		❑ Palpitations	
❑ Swollen glands in neck		❑ Shortness of breath	
❑ Sore throat or voice changes		❑ Swelling of ankles/hands/feet	
❑ Environmental Allergies		❑ Passing out spells	
Respiratory	When:	**Gastrointestinal**	When:
❑ Chronic or frequent coughs		❑ Loss of Appetite	
❑ Spitting/coughing up blood		❑ Heartburn	
❑ Asthma or wheezing		❑ Nausea/Vomiting/Diarrhea/Constipation	
❑ Shortness of breath		❑ Change in Bowel Movements	
Musculoskeletal	When:	**Skin**	When:
❑ Joint pain/stiffness/swelling/warmth		❑ Rash or itching	
❑ Weakness of muscles or joints		❑ Sunburns as a child	
❑ Muscle pain or cramps		❑ Change in skin color/moles	
❑ Back pain		❑ Change in hair or nails	
❑ Difficulty walking		❑ Varicose Veins	
Neurological	When:	**Psychiatric**	When:
❑ Light headed or dizziness		❑ Memory Loss or confusion	
❑ Convulsions or seizures		❑ Difficulty with anger	
❑ Numbness or tingling sensations		❑ Nervousness	
❑ Tremors		❑ Depression	
❑ Stroke/TIA		❑ Trouble Sleeping	
❑ Head Injury		❑ Hospitalized for emotional problems	
Endocrine	When:	**Hematologic/Lymphatic**	When:
❑ Gland or hormonal problems		❑ Slow healing cuts or bruises	
❑ Thyroid Disease		❑ Anemia	
❑ Problems with blood sugar/diabetes		❑ Past blood transfusions	
❑ Frequent Thirst for no reason		❑ Enlarged lymph nodes in groin/armpits	
❑ Heat or cold intolerance		❑ Easier bruising than usual for you	
FOR WOMEN:	When:	**FOR MEN:**	When:
Genitourinary		**Genitourinary**	
❑ Frequent Urination		❑ Frequent Urination	
❑ Burning/Painful Urination		❑ Burning/Painful Urination	
❑ Frequent urination at night		❑ Frequent urination at night	
❑ History of kidney infections/stones		❑ History of kidney infections/stones	
❑ Blood in urine		❑ Blood in urine	
❑ Vaginal discharge/odor/itching		❑ Erectile dysfunction	
❑ Pain during sex		❑ Testicular pain	
❑ Lack of sexual desire		❑ Lack of sexual desire	
❑ Painful/heavy periods		❑ Discharge from penis	
❑ PMS or Menopausal symptoms		❑ Pain during sex	

Patient Central
Urgent Care • Primary Care • Heart Care

Protected Health Information Patient Preferences

Please help us accommodate your wishes regarding how we communicate with you about your health care by completing and signing this form.

❑ Yes ❑ No May we use your first name, last name, or both to identify you in the waiting room? If not, how would you prefer to be identified?

_____

❑ Yes ❑ No May we leave a message on your answering machine or voicemail reminding you of an appointment, or requesting that you call our office? If not, is there an alternate method of contacting you by phone?
❑ Portal ❑ Cell ❑ Other

_____

❑ Yes ❑ No May we leave information regarding an upcoming appointment or a request for you to call us with another individual in your household?

❑ Yes ❑ No May we send written correspondence in a sealed envelope to your home address? If not, is there an alternative address where we may send confidential communications to?

_____

❑ Yes ❑ No Is there another person with whom you give permission for us to speak with about your health care? If yes, please list name(s) and relationship.

_____

_____

_____

Please list any physicians you would like copies of office notes and test results sent to.

_____

_____

_____

_____

➡ _____ _____

Signature of Patient or Legal Guardian Date

Thank you for choosing Patient Central.
We look forward to caring for you!

Patient Central
Primary Care • Urgent Care • Heart Care

Are You At Risk of HEART ATTACK?

Patient Name: _____

Date of Birth: _____ Today's Date: _____

Have you recently experienced any of the following symptoms?

- ❑ Chest Pain / Pressure / Aching
- ❑ Neck or Jaw Tightness
- ❑ Heart Racing or Skip Beats
- ❑ Dizziness
- ❑ Leg Heaviness or Cramping
- ❑ Persistent Sores on Legs
- ❑ Heart Burn
- ❑ Shortness of Breath
- ❑ Unusual Sweating
- ❑ Loss of Consciousness
- ❑ Leg Swelling
- ❑ Unusual Fatigue/Weakness

Do you have any of the following conditions?

- ❑ High Blood Pressure
- ❑ Diabetes
- ❑ Family History of Heart Disease
- ❑ Heart Murmur or Heart Valve Problem
- ❑ Carotid Artery Disease
- ❑ Known Heart Disease
- ❑ High Cholesterol
- ❑ Smoking History
- ❑ PAD (Peripheral Arterial Disease)
- ❑ Varicose Veins
- ❑ Obesity
- ❑ Stroke History

Prevent Heart Disease!

www.samedayheartcare.com