



FAMILY MEDICAL • URGENT CARE

Welcome To Your Neighborhood Urgent Care!

- New Patient
- Patient Update

REFERRAL SOURCE- How did you hear about us?

- Friend / Family _____
- Previous patient
- Walk In / Signage
- Other Doctor _____
- Yellow pages
- Website
- Attorney _____
- Insurance Listing
- Other _____

PATIENT INFORMATION

Date ____/____/____ Patient Name _____
(Last) (First) (Init.)
Date of Birth ____/____/____ Age: _____ Sex: M F
Social Security # _____ Marital Status: Single Married Divorced Widowed
Race: Decline American Indian/Alaska Native Asian Black/African American
 Native Hawaiian/Other Pacific Islander White Other Race
Ethnic Group: Decline Hispanic/Latino Not Hispanic/Latino Language: _____
Address _____ City _____ State _____ Zip Code _____
Home # _____ Mobile # _____ Work # _____
E-Mail: _____ Occupation _____ Employer _____
Emergency Contact _____ Relationship _____ Phone # _____
Spouse Name _____ Social Security # _____ Date of Birth ____/____/____
Spouse Employer _____ Phone # _____

INSURANCE INFORMATION

Primary Insurance: _____ Telephone # _____
Address _____ City _____ State _____ Zip _____
Name of Policy Holder _____ Date of Birth ____/____/____
Relationship to Patient _____ Employer _____
Member Id # _____ Group Id # _____ Social Security # _____

Secondary Insurance: _____ Telephone # _____

Address _____ City _____ State _____ Zip _____
Name of Policy Holder _____ Date of Birth ____/____/____
Relationship to Patient _____ Employer _____
Member Id # _____ Group Id # _____ Social Security # _____

HEALTH SUMMARY

Problem List/Reason for Today's Visit: Please check one box

Well visit Health Check-Up/Establish Care

Please tell us when your last physical exam was _____ (month/date/year)

"Sick" Visit

Please allow the medical provider to address the **most** important symptom of concern. This will allow them to thoroughly evaluate, work-up and /or treat this chief concern accordingly.

Chief Complaint _____

When did this start? _____

Have you ever had any labs or testing associated with this concern? If yes, please list _____

Allergies: none

Allergy _____ Reaction: _____

Allergy _____ Reaction: _____

Drug Allergies : No Known Drug Allergies

Drug _____ Reaction: _____

Drug _____ Reaction: _____

Drug _____ Reaction: _____

Drug _____ Reaction: _____

Preferred Pharmacy: _____

Address/Cross Street _____ Phone Number: _____

Current Medications:

Drug	Strength	Dosing (example: once a day)

Do you have any Advanced Directives? Living Will Do Not Resuscitate Power of Attorney Organ Donor

Other: _____ Month/Year Directives signed : _____

Past Medical History:

Medical Condition: _____ Month/Year Diagnosed _____

Medical Condition: _____ Month/Year Diagnosed _____

Medical Condition: _____ Month/Year Diagnosed _____

Medical Condition: _____ Month/Year Diagnosed _____

Medical Condition: _____ Month/Year Diagnosed _____

Medical Condition: _____ Month/Year Diagnosed _____

Other Medical Providers/Specialist:

Provider's Name: _____ Specialist: _____

Provider's Name: _____ Specialist: _____

Provider's Name: _____ Specialist: _____

Preventive Health Maintenance:

Have you had any of these tests performed? If so, please indicate date of the most recent testing done and results.

*Boxes left empty will indicate test never performed or immunization never received.

Cardiac Testing		
<i>Test</i>	<i>Date Performed (month/year)</i>	<i>Results</i>
EKG		
Exercise Stress Test		
Stress Echocardiogram		
Nuclear Stress Test		

Echocardiogram		
Aortic Ultrasound		
Lower Extremity Arterial Ultrasound		
Carotid Doppler		
Pulmonary Testing		
<i>Test</i>	<i>Date Performed (month/year)</i>	<i>Results</i>
Chest X-Ray/ CT Chest		
Spirometry		
Diabetic Testing		
<i>Test</i>	<i>Date Performed (month/year)</i>	<i>Results</i>
Diabetic Monofilament Test		
Podiatric Evaluation		
Ophthalmologic/Retinal Eye Exam		
Labs for Diabetes		
Gastrointestinal Testing		
<i>Test</i>	<i>Date Performed (month/year)</i>	<i>Results</i>
Endoscopy		
Colonoscopy		
Fecal Occult Guiac Test		
Women's Health		
<i>Test</i>	<i>Date Performed (month/year)</i>	<i>Results</i>
Pap Smear		
Mammogram		
Bone Density Test		
Immunizations		
<i>Vaccine</i>	<i>Date Given (month/year)</i>	
Tetanus		
Pneumococcal		
Zostavax		
Influenza		
Miscellaneous Tests (i.e. sleep study, lead level, hearing test, allergy testing, ect)		
<i>Test</i>	<i>Date Performed (month/year)</i>	<i>Results</i>

Surgical History:

Surgery _____ Date (month/year) _____
Surgery _____ Date (month/year) _____
Surgery _____ Date (month/year) _____

Family History: (diabetes, high blood pressure, high cholesterol, cancers, heart disease, ect)

Medical Condition	Which family member?

Social History:

Occupation: _____ Marital Status: _____
Number of Children _____ Other: _____

Tobacco/Alcohol/Supplements:

never smoked past smoker, quit date: _____ currently smokes _____ cigs/day or _____ ppd
 drinks no alcohol rarely/occasionally drinks history of alcoholism currently alcoholic
Other: _____

Substance Abuse History: none

history of abusing: _____ currently abuses: _____

Mental Health History:

Mental Health Condition: _____ Month/Year Diagnosed _____
Mental Health Condition: _____ Month/Year Diagnosed _____
Mental Health Condition: _____ Month/Year Diagnosed _____

Have you recently had any symptoms of depression (i.e. little interest in doing things, feeling down or hopeless)?

no yes If so, how long have you been experiencing these symptoms? _____

Any history of Communicable Diseases (i.e. STIs, or Tuberculosis)? _____

HIPPA/ INSURANCE AUTHORIZATION & RELEASE

HIPAA COMPLIANCE

- Your personal health information cannot be shared unless to prevent serious threat to your health or others.
- Your personal health information may be disclosed, if required to do so by law.
- You have the right to access your medical file and billing records.
- You have the right to request that we amend your information.
- You may revoke any written authorization given to us.
- All requests must be presented to this office in writing.

I allow my treatment/medical records to be released to: _____ Relationship _____

INSURANCE ASSIGNMENT AND RELEASE

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to **SUNSET CLINIC**. I authorize **SUNSET CLINIC** to release any information required to process my claims. I understand it is my responsibility to make sure my account is paid by my insurance company. I have verified with my insurance company that **SUNSETCLINIC** is a participating provider. I understand that I am fully financially responsible if there are any unpaid claims by my insurance company for any reason.

Patient Signature: _____ Date: _____

NON-DISCRIMINATORY STATEMENT

Sunset Clinic does not discriminate based on age, ethnicity, race, religion or sex.
Sunset Clinic provides medical treatment based on patients needs and standards of care.

Patient Signature: _____ Date: _____