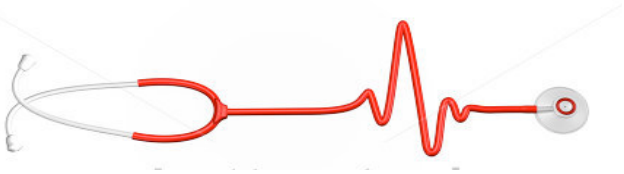
Wyoming Urgent Care



Because illnesses don't happen by appointment.

TODAY'S DATE: _____

PATIENT'S NAME: _____**DOB:** _____

ADDRESS: _____**Town, State**_____

PHONE: _____**CELL PHONE:** _____

EMAIL: _____ **PARENT/GUARDIAN SSN:** _____

PRIMARY PHYSICIAN_____**PHONE:**_____

EMERGENCY CONTACT: _____**PHONE:**_____

WHAT KIND OF INSURANCE DO YOU HAVE: _____

POLICY NUMBER: _____ **SUBSCRIBER:** _____**DOB**_____

SECONDARY INSURANCE_____

POLICY NUMBER: _____ **SUBSCRIBER:** _____**DOB**_____

Allergy _____

Reason for the visit_____

PRESENT ILLNESS:

- Is Injury Motor Vehicle Related? ☐Yes ☐No If yes, Date of accident: _____
- How long have you had this problem: _____
- Severity of your pain (Circle one): 1 2 3 4 5 6 7 8 9 10

GENERAL MEDICAL INFORMATION:

HEIGHT: _____ WEIGHT: _____

Please tell receptionist if you have any of the following: Abdominal pain Chest Pain
Confusion Numbness of arm or leg Sudden loss or change of vision

Please list medications you are currently taking: _____

_____

SURGICAL/HOSPITAL HISTORY

What surgeries or hospitalization have you had, and when? _____

List any ongoing medical conditions: _____

_____

FAMILY MEDICAL HISTORY:

_____

_____

CONSENT TO TREAT:

I hereby consent to medical evaluation, testing and/or treatment provided to me by the Wyoming Urgent Care staff. I understand that such medical care may include history taking, diagnostic testing and administration of medication and/or treatment. I understand I may discontinue treatment or any part thereof.

DISCLOSURE OF MY PROTECTED HEALTH INFORMATION:

I understand that Wyoming Urgent Care may use or disclose my Protected Health Information to carry out treatment, payment, or healthcare. Any information concerning mine (or my child's) health care, advice and treatment provided for the purpose of obtaining insurance benefits.

ASSIGNMENT OF BENEFITS:

I also hereby authorize payment of insurance benefits, otherwise payable to me be made directly to Wyoming Urgent Care. I understand I am responsible for any balance not paid by my insurance.

Signature of patient or responsible party _____Date_____

Print Name: _____Relationship_____

How did you find out about Wyoming Urgent Care? _____

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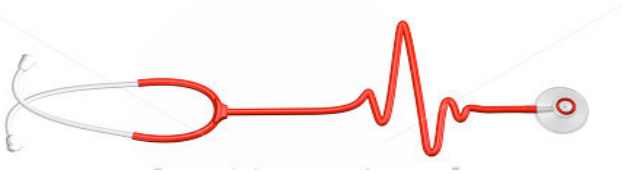

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Consent Form for Treatment of Minor Child

I, _____ hereby authorize Wyoming Urgent Care Representative,

to administer the necessary medical care to my son/daughter.

Name of Child: _____

DOB: _____

Sex: F M

Signature: _____

Printed Name: _____

Witnessed by: _____

Printed Name: _____

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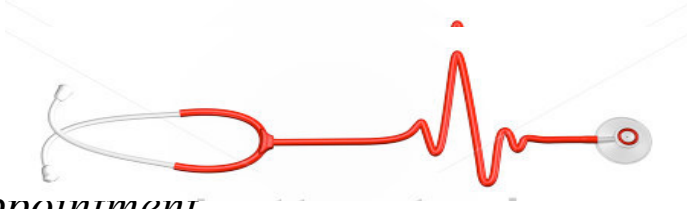

HIPAA form to be sign by patient

RIGHT TO RECEIVE NOTICE OF CHANGE TO WYOMING URGENT CARE PRIVACY STATEMENT

You have the right to receive any changes to our privacy statement that affect you on or after the effective date of change. If you have any questions about this notice contact any of the contact persons listed below.

Dr. Lesly Germain

Wyoming Warsaw Urgent Care

76 North Main Street, Warsaw, NY 14569

Tel: 585-786-0101

I hereby acknowledge that I have received a copy of this practice's **NOTICE OF PRIVACY PRACTICES**. I understand that if I have questions or comments regarding my privacy rights that I may contact any of the persons listed above. I further understand that the practice will offer me updates to this **NOTICE OF PRIVACY PRACTICES** should it be amended, modified, changed in any way.

Please list the names of any persons to whom you wish us to disclose your PHI and state how the individual is related to the patient:

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Other uses and disclosures require your written authorization

Signature: _____Date:_____

Witness: _____Date:_____