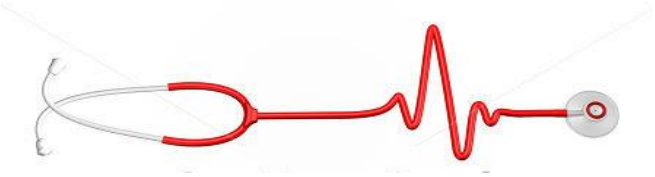
Wyoming Urgent Care



Because illnesses don't happen by appointment.

TODAY'S DATE: _____

PATIENT'S NAME: _____DOB: _____ Marital Status: S M W Dv Sp

ADDRESS: _____Town, State_____

PHONE: _____CELL PHONE: _____SSN:_____

EMAIL: _____EMPLOYER:_____ _____PHONE:_____

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:

- Did this Injury happen at work ☐Yes ☐No If yes, Date of 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:

Are you pregnant? ☐Yes ☐No 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: _____

Alcohol Consumption: ☐Daily ☐Weekly ☐Monthly ☐Rarely ☐Never

Tobacco Use:
How much per day _____ When did you start: _____ Quit: ☐Yes ☐No When: _____

Illegal Drug Use: ☐Daily ☐Weekly ☐Monthly ☐Rarely ☐Never

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.

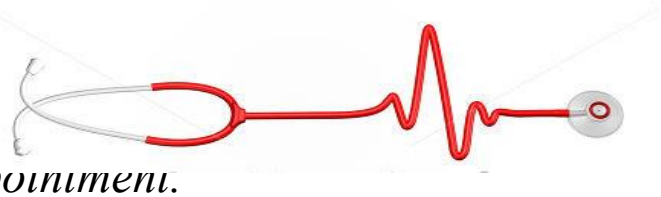
ASSIGNMENT OF BENEFITS:

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? _____



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:_____