URGENT CARE
By URGENT SPECIALISTS

NEW PATIENT FORM

Last Name	MI	First Name

Address	Apt/Unit #	City:	State	Zip code

DOB	SSN ONLY FOR TRICARE PATIENTS	Gender	Preferred Language

Phone (H)	(C)	PREFERRED METHOD OF CONTACT:

☐ WORKER'S COMP CASE	Email:

Employer	Employer Phone	Occupation

RACE		ETHNICITY	MARITAL STATUS

HOW DID YOU HEAR ABOUT US?	Primary Care Physician (Name & Address)

Emergency Contact	Phone	Relationship to Patient

INSURANCE INFORMATION

Primary Insurance:	Relationship to Insured	*PROVIDE NAME & DOB OF PRIMARY HOLDER* Name: DOB:
Secondary Insurance:	Relationship to Insured	*PROVIDE NAME & DOB OF PRIMARY HOLDER* Name: DOB:

FINANCIAL RESPONSIBILITY

Responsible Party Name ☐ Self	Relationship to Patient	SSN	DOB

Primary Phone	Address

PREFERRED PHARMACY

Pharmacy Name and Phone	Pharmacy Cross Streets

VITALS	VISION ACUITY

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CONSENT TO TREATMENT

By signing below, I (or my authorized representative on my behalf) authorize Urgent Specialists L.L.C. and their staff to conduct diagnostic examinations, tests, and procedures to assess, diagnose, and treat my illness(es) and/or injury(ies). I authorize Urgent Specialists to provide medications, treatment, or therapy necessary to effectively assess and maintain my health. I understand that it is the responsibility of my individual treating healthcare provider(s) to explain to me the reasons for any diagnostic examination, test or procedure, the available treatment options, and the common risks. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment. It is my responsibility to pay for services rendered. I understand that Urgent Specialists will collect payment from my insurance company(ies) on my behalf, but I am ultimately responsible for payment if my insurance does not cover my fees obtained at Urgent Specialists L.L.C. I understand my care may have additional charges billed by outside facilities (i.e., labs, x-rays, and splints) that may not be covered by my insurance carrier and therefore will be my responsibility.

STATEMENT OF LIMITATION REGARDING ADVANCE DIRECTIVE

Our team is dedicated to delivering the highest quality care in a safe environment that places the patient at the center of our care. Most treatments performed at Urgent Specialists are minimal risk. It I policy of Urgent Specialists that if an adverse event occurs during your treatment, the medical team will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital, further treatment or withdraw of treatment measures already begun will be ordered in accordance with you wishes, advance directive, or health care power of attorney.

If you do have an Advanced Directive or Living Will and wish to provide us with a copy of the document, we will place a copy in your medical record. In the event of transfer to a hospital is required a copy will be forwarded to the hospital.
If you do not have an Advanced Directive/Living Will and wish to create one you may refer to one of the following:
www.willsofamerica.com https://health.mo.gov/safety/homecare/pdf/Directives.pdf
www.legalzoom.com

If you would like a copy of the State of Missouri official Advance Directives form, please ask when you arrive at the center and a copy will be provided to you.

HIPAA NOTICE OF PRIVACY PRACTICES

Signature below is only acknowledgement that you have received the Notice of our Privacy Practices.

HEALTHCARE PROVIDER INFORMATION

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

NOTICE OF PATIENT RIGHTS

Signature below is only acknowledgement that you have received the Notice of Patient Rights.

NOTICE OF LIMITATION REGARDING ADVANCE DIRECTIVE

Signature below is acknowledgement that you understand the limitation regarding advance directive.

AUTHORIZATION TO DISCUSS MEDICAL INFORMATION

I hereby authorize the staff of Urgent Specialists to disclose medical information (results of tests, care plan, medications, diagnosis, appointment times/dates, etc.), to the parties listed below.

Individual(s) authorized to receive information:

Name:	**Name:**
Relationship:	**Relationship:**
Phone:	**Phone:**

I understand the following:
• This authorization will remain in effect from the date signed below until the patient revokes it.
• I may revoke this authorization in writing, delivered by patient to Urgent Specialists.
• This authorization is giving Urgent Specialists the right to discuss my medical information with the one or more individuals listed above.
• Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by the HIPAA.
• I may refuse to sign this authorization and you will not condition treatment or payment on my providing authorization.

Patient Signature (or Legal Guardian) _____

Name (Printed) _____ **Date:** _____

URGENT SPECIALISTS

NEW PATIENT MEDICAL HISTORY FORM

TODAY'S DATE: _____

Last Name	First	MI
DOB: _____/_____/_____	☐ WORKER'S COMP CASE	
REASON FOR VISIT TODAY:		

ALLERGIES TO MEDICATIONS:	REACTIONS:

Are you allergic to Latex? ☐

Any other allergies?

If yes, please list: _____

CURRENT MEDICATIONS:

MEDICATION:	DOSE:	FREQUENCY:

MEDICAL HISTORY:	Y	N		Y	N		Y	N
ABNORMAL HEART RATE	☐	☐	DIABETES	☐	☐	LUNG CANCER	☐	☐
ARTHRITIS	☐	☐	EYE /GLAUCOMA	☐	☐	PRIOR PAIN MANAGEMENT	☐	☐
ASTHMA	☐	☐	GASTROINTESTINAL DISEASE	☐	☐	OSTEOPOROSIS	☐	☐
ALLERGIES - SEASONAL	☐	☐	GERD / REFLUX	☐	☐	OTHER CANCERS	☐	☐
AUTOIMMUNE / RHEUMATOLOGICAL	☐	☐	HEADACHES	☐	☐	SKIN RASH	☐	☐
BREAST CANCER	☐	☐	HEART ATTACK	☐	☐	SEIZURE DISORDER	☐	☐
CLOTTING DISORDER	☐	☐	HEART DISEASE	☐	☐	SLEEP APNEA	☐	☐
COLON CANCER	☐	☐	HIGH BLOOD PRESSURE	☐	☐	STROKE	☐	☐
CONCUSSION	☐	☐	HIGH CHOLESTEROL	☐	☐	THYROID	☐	☐
CONGESTIVE HEART FAILURE	☐	☐	HIV / AIDS	☐	☐	VASCULAR DISEASE	☐	☐
COPD / EMPHYSEMA	☐	☐	IBS	☐	☐	ALCOHOL ABUSE	☐	☐
DEMENTIA	☐	☐	KIDNEY DISEASE	☐	☐	SUBSTANCE ABUSE	☐	☐
DEPRESSION / ANXIETY	☐	☐	LIVER DISEASE	☐	☐	PSYCHIATRIC DISORDER	☐	☐

URGENT SPECIALISTS

NEW PATIENT MEDICAL HISTORY FORM (PAGE 2)

Last Name	First	MI

Any other Medical Problems: _____

Are you pregnant or breastfeeding?

SURGICAL HISTORY:	Y	N		Y	N		Y	N
APPENDIX	☐	☐	HERNIA	☐	☐	PACEMAKER	☐	☐
C-SECTION	☐	☐	HIP REPLACEMENT	☐	☐	TONSILS	☐	☐
HEART BYPASS	☐	☐	HYSTERECTOMY	☐	☐	TUBAL LIGATION	☐	☐
CARDIAC CATH	☐	☐	KNEE REPLACEMENT	☐	☐	VASCULAR PROCEDURE	☐	☐
GALLBLADDER	☐	☐	MASTECTOMY	☐	☐	VASECTOMY	☐	☐
EAR TUBES	☐	☐	NECK / BACK SURGERY	☐	☐	V-P SHUNT	☐	☐

ANY MAJOR INJURIES

If yes, please provide injury, month, and date: _____

FAMILY HISTORY:

	DECEASED	HEALTHY	UNKNOWN	HEART DISEASE	DIABETES	HYPERTENSION	STROKE	HIGH CHOLESTEROL	BREAST CANCER	COLON CANCER	LUNG CANCER	MELANOMA	OVARIAN CANCER	CANCER	OSTEOPOROSIS	ASTHMA	KIDNEY DISEASE	THYROID DISEASE	LIVER DISEASE	DEPRESSION
FATHER	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
MOTHER	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
SISTER	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
SISTER	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
BROTHER	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
BROTHER	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
M. GRANDMOTHER	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
P. GRANDMOTHER	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
M. GRANDFATHER	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
P. GRANDFATHER	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

SOCIAL HISTORY:

Do you smoke?	☐ Yes ☐ No	If yes, how much?	How many years?
If you quit smoking, when did you quit?			
Do you use alcohol?	☐ Yes ☐ No	If yes, number of drinks per week?	
Drug Use?	☐ Yes ☐ No		

WORK HISTORY:

Current/Planned Job Title:	
How many years in this position?	