Best Health Urgent Care

New Patient Registration Form

Last Name: _____First Name:_____

Date of Birth:_____ Age:_____ SSN:_____

Parent/Guardian Name(s): _____

Address: _____ Cell:_____

City:_____State:_____Zip:_____ Home: _____

Email Address: _____

I hereby permit the following means of communication related to my personal health, treatment, diagnosis, test result (including HIV) or billing as noted:

☐ All of the following are acceptable ☐ Phone ☐ Text ☐ Voicemail ☐ E-mail ☐ Mail

If you **do not** consent BHUC to release medical records (including HIV test results) to your PCP listed below, please initial here _____

Primary Care Physician Information

Primary Care Doctor: _____

Address:_____ Phone:_____

Pharmacy Information

Pharmacy Name:_____ Pharmacy Address:_____

Pharmacy Phone: _____

Payment Information

☐ I have insurance. Please provide your insurance card and valid ID ☐ I do not have insurance/Self-Pay.

Insurance Company Name: _____

Subscriber Name:_____ Relation to patient: _____

☐ Address is same as Patient's Address, if not please fill below section

Address: _____

Date of Birth: _____ SSN: _____

Demographic Information

Ethnicity/Race: ☐ Asian ☐ African American ☐ Hispanic/Latino ☐ White/Caucasian ☐ Other

HIPPA Authorization to Disclose and Emergency Contacts

It is the policy of Best Health Urgent Care not to release confidential medical information to patient's family members. We cannot discuss your medical condition, clinical diagnosis, or release medical test results to anyone without your consent. I hereby give consent that my personal health information, treatment, diagnosis, test results or billing information can be given to the following person(s):

Name: _____Phone: _____ Relationship:_____

Name: _____Phone: _____ Relationship:_____

☐ Check here if you choose the same person(s) as your emergency contact

Reason for Visit

What is the reason of your visit today:_____

How long have you had symptoms: _____

What are your symptoms: (Example: fever, sore throat):_____

_____

Allergies

☐ I do have allergies; fill below ☐ I do not have allergies _____ (initial here)

Allergies(to medications, food or environment): _____

If you do have allergies, what is the reaction: _____

Medication List:

(if you do not take medications, please write n/a)

1. _____
2. _____
3. _____
4. _____
5. _____

Surgical History

1. _____
2. _____
3. _____

Family History of Illness:

1. _____
2. _____
3. _____
4. _____
5. _____

Social History

Alcohol: (yes or no) If yes, specify:_____

Cigarettes: (yes or no) If yes, specify:_____

Drug Use: (yes or no) If yes, specify:_____

Consent for Treatment

I, the undersigned, consent to the care and the treatment by the attending physicians/advanced practice providers, his/her associates or assistants and acknowledge that no guarantees have been made as to the effect of such treatment:

_____ _____

Signature of Patient or Patient Guardian Print Patient's Name Date

Notice of Privacy Practices, HIPAA Authorization to Disclose, Financial Policy, Consent Form, Treatment & E-Prescribe

I have reviewed the detailed notice of privacy practice and other disclosures as provided at registration and understand that I may request a copy of the policy at any time.

_____ _____

Signature of Patient or Patient Guardian | Print Patient's Name | Date