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RACE		PRIMARY LANGUAGE
ETHNICITY	HISPANIC/ LATINO	NON-HISPANIC/ LATINO

PATIENT INFORMATION FORM

Patient Name			Social Security Number
Date of Birth	Marital Status S M D W P	Address	
Home Phone OK to leave message? Yes No		City State Zip	
Email address		Employer's Name/Occupation	
Mobile Phone or Pager OK to receive text messages? Yes No		Work Phone OK to leave message? Yes No	
Emergency Contact	Relationship		Emergency Contact Phone
Primary Care Physician		**Insurance** Name of Insurance Co_______________	
Pharmacy with two cross streets		ID# _______________	
How were you referred to our practice? ☐ Newspaper ☐ Friend ☐ Internet ☐ Sign/Drive By ☐ Yellow Pages ☐ Other _______________		Group# _______________ Phone# _______________	

Insured and/or Parent/Guardian Information

Insured's Name		Social Security Number
Date of Birth	Relationship to patient	Address *(if different from above)*
Home Phone		City State Zip
Work Phone		Employer's Name

Benefits Assignment

I hereby authorize the assignment of benefits (payments) directly to Excel Urgent Care for all my insurance claims related to services received. I agree to pay any and all charges that exceed, or are not covered by my insurance

Signature of Responsible Party:___________________________________ Date:_____________________

Records Release

I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company; in addition, I authorize the release of medical records to the responsible insurance carrier if my injury/illness occurred at the workplace. I permit a copy of this authorization to be used in place of the original.

Signature of Responsible Party:___________________________________ Date:______________________

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ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

____
Signature of Patient or Personal Representative

____
Date

____
Name of Patient or Personal Representative

____
Description of Personal Representative's Authority

You have my permission to discuss my medical care/account with:

____
Name

____
Relationship

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Patient Financial Policy Sheet

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience we accept cash and the following major credit cards VISA and MasterCard.

Uninsured/Cash patients are required to pay a $120 deposit prior to being seen which will apply to your office visit.
Your Insurance: Please initial the following showing that you understand and accept our financial policy.

_________ • We will verify your insurance benefits to the best of our ability via internet and customer service lines. Some insurances cannot be verified after hours or weekends. Additional payment may be due after your insurance company processes your claim according to your benefits.

_________ • In the event we cannot verify your insurance benefits while you are in our office or if you have insurance coverage with a plan for which we do not have a prior arrangement; we will expect payment in full at time of service.

_________ • By signing this form, you authorize Excel Urgent Care to balance bill your credit/debit card for any balance Your insurance company deems to by your responsibility per the Explanation of Benefits (EOB}. A courtesy call will be made to debit.card holders if balance is greater than $40. A receipt will be mailed to you. We do not send out statements. The alternative to leaving a card for balance billing is to pay in full at time of service and be refunded when insurance pays Excel Urgent Care. All refunds must be placed on card used for original transaction.

- **For all services rendered, we look to the adult accompanying the patient and the patient and the parent or guardian with custody for payment.**

I have read and understand the financial policy of the practice and agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time. In the event the account must be placed with a collection agency, I agree to reimburse Excel Urgent Care for any collection agency fees, which may be based on a maximum percentage of 20% of the debt. I agree to reimburse Excel Urgent Care for all costs and expenses, including reasonable attorney fees Excel Urgent Care should incur in such collection efforts. Chargeback Fees -- I agree to reimburse Excel Urgent Care any chargeback fees incurred at the time a charge is disputed with my bank.

______________________________	______________________________
Printed Name of Patient	Signature of Patient or Responsible Party
______________________________	______________________________
Date of Birth	Date

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Medical History Questionnaire

What is the reason for today's visit?

____

Do you have any allergies? (Environmental and/or medications) OYes ONo

If yes, please explain: ____

Have you ever had a reaction to Novacaine, Lidocaine, bandages, or topical antibiotics (Neosporin)?· OYes ONo

Are you pregnant? OYes ONo Are you breastfeeding? OYes ONo

Please list below current medications you are taking (including prescriptions, over the counter needs, vitamins, herbal supplements):

1. ______________________ 2. ______________________ 3. ____________________
4. ______________________ 5. ______________________ 6. ____________________

Have you ever had or do you currently have:

Bronchitis	OYes	Aneurysm	OYes	Kidney Disease/Failure	OYes
Allergic Rhinitis	OYes	Migraines or recurring headaches	OYes	Dialysis	OYes
Sinusitis	OYes	Stroke or TIA	OYes	Urinary Tract Infection	OYes
Ear infection	OYes	Anxiety	OYes	Enlarged Prostate or infection	OYes
Emphysema/ COPD	OYes	Depression	OYes	Pelvic infections	OYes
Asthma	OYes	Bipolar Disorder	OYes	Ovarian Cyst	OYes
Lung Disease	OYes	Acid Reflux	OYes	Sexually Transmitted Disease	OYes
High Blood Pressure	OYes	Heart Burn	OYes	HIV, Hepatitis	OYes
Heart Disease	OYes	Diabetes	OYes	Thyroid Disease	OYes
High Cholesterol	OYes	Peptic Ulcer Disease	OYes	Arthritis	OYes
Inflammation of Vein	OYes	Pancreatitis	OYes	Gout	OYes
Blood Clots/ DVT	OYes	Diverticulitis	OYes	Artificial Joints	OYes
Bleeding Disorder	OYes	Intestinal or Colon problems	OYes	Fibromyalgia	OYes
Fainting	OYes	Gallbladder Disease / Gallstones	OYes	Back Problems	OYes
Seizures	OYes	Liver Disease	OYes	Skin disorders	OYes
Anemia	OYes	Bladder or Kidney Infection	OYes	Immunizations up to date?	OYes
Cancer	OYes	Kidney Stones	OYes		

I have no history of significant medical problems **OYes**

List any other diseases or conditions

Surgeries:

O Appendectomy O Pacemaker O Back O Tonsillectomy
O Gallbladder O Hysterectomy O Heart Bypass

Have you had any surgery? OYes ONo
Please specify: ______________________

Social History:

Do you now or have you ever used alcohol?	OYes	ONo	How much:_________
Do you now or have you ever used tobacco?	OYes	ONo	How much:_________
Do you use any drugs (including marijuana)?	OYes	ONo	How much:_________

Family Medical History

	None	Diabetes	High Blood Pressure	Heart Disease	Other
Mother	O	O	O	O	______________________
Father	O	O	O	O	______________________
Sister	O	O	O	O	______________________
Brother	O	O	O	O	______________________
Daughter	O	O	O	O	______________________
Son	O	O	O	O	______________________

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Name:______________________ DOB:____/____/____ Date:____/____/____

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COMPREHENSIVE REVIEW OF TODAY'S SYMPTOMS

Please fill in **YES** circles that apply to you today

Genitourinary female

Painful menstrual cycle OYes
Pelvic pain OYes
Irregular periods OYes
Vaginal itching OYes
Abnormal vaginal discharge OYes

Musculoskeletal

Joint stiffness OYes
Joint pain OYes
Joint swelling OYes
Back pain OYes
Neck pain OYes
Muscle aches OYes

Constitutional

Loss of appetite OYes
Fever OYes
Weakness OYes

ENT

Nose bleeds OYes
Sore throat OYes
Ear pain OYes

Cardiology

Palpitations OYes
Chest pain OYes

Gastroenterology

Diarrhea OYes
Vomiting OYes
Constipation OYes
Nausea OYes
Abdominal pain OYes

Dermatology

Itching OYes
Rash OYes

Endocrinology

Excessive thirst OYes
Excessive sweat OYes
Cold intolerance OYes
Heat intolerance OYes

Neurology

Headache OYes
Tingling/numbness OYes
Dizziness OYes

Ophthalmology

Drainage from eyes OYes
Blurring of vision OYes
Eye irritation OYes

Respiratory

Shortness of breath OYes
Cough OYes
Congestion OYes

Allergy

Runny nose OYes
Itchy eyes OYes
Sneezing OYes

Hematology/lymph

Swollen glands OYes
Fatigue OYes

Urology

Difficulty urinating OYes
Blood in urine OYes
Frequent urination OYes
Urinary incontinence OYes

Other ____________________________

Name:____________________ DOB:____/____/____ Date:_____/_____/_____