

Frisco Urgent Care & Clinics

PATIENT INFORMATION

Name (<i>First, Mi., Last</i>):	Date of Birth:	Age:
Sex: Male / Female	Marital Status: S M W D	
Address:		
Home Phone #:	Social Security #:	Driver's License #/State/Exp:
Work #:	Cell Phone#:	Email:
Primary Language :English/Spanish/other	Emergency Contact:	Phone #:

RESPONSIBLE PARTY OR SPOUSE INFORMATION

Name:	Relationship to Patient:
Address:	
Phone #:	Social Security #:
Employer & Address:	Work #:

INSURANCE INFORMATION

Primary Ins. & Address:		
Group #:	Certificate or ID # :	Phone # :
Insured's Name:	Relationship to Patient: Self / Spouse / Dependent	
Insured's Employer:	Phone #:	
Employer's Address:		
Insured's Social Security #:	Date of Birth:	Sex: Male / Female
Secondary Ins. & Address:		
Group #:	Certificate or ID #:	Phone# :
Insured's Name:	Relationship to Patient: Self/ Spouse / Dependent	
Insured's Employer:	Phone # :	
Employer's Address:		
Insured's Social Security # :	Date of Birth:	Sex: Male / Female

I hereby assign, transfer, and set over to Frisco Urgent Care & Clinics all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Signature: _____ **Relationship:** _____ **Date:** _____

Patient's name:

Frisco Urgent Care & Clinics

CHIEF COMPLAINT(S): _____

CURRENT MEDICATIONS & dosages (include non-prescription):

1.	9.
2.	10.
3.	11.
4.	12.
5.	13.
6.	14.
7.	15.

PAST MEDICAL HISTORY

Please list your *current and past medical/surgical/gynecological* conditions

1.
2.
3.
4.
5.

PREVIOUS SURGERIES

Type	When?	Where?
1.		
2.		
3.		
4.		
5.		

Patient's name:

PREVIOUS HOSPITALIZATIONS

Why?	When?	Where?
1.		
2.		
3.		
4.		
5.		
6.		

FEMALES — OB/GYN HISTORY

Pain with periods	no yes	Irregular Periods	no yes	Vaginal Discharge	no yes
Date of last pap smear		Abnormal Pap	no yes	Date of last mammogram	
Date of last period		Heavy periods	no yes	Hot flashes	no yes
Infertility	no yes	Sexually active	no yes		
Frequent yeast infections	no yes	PMS	no yes		
# of Pregnancies		# of Miscarriages			
# of Stillbirths					
# of abortions					

PATIENT SOCIAL HISTORY

Marital Status:	married	single	separated	divorced	widowed
Alcohol use:	never	rarely	moderate/# of drinks per day:	heavy/# of drinks per day	
Tobacco use:	never	quit/when	maximum # of cigarettes/day	smoking since age	
Use of drugs:	never	in the past/type	currently/type		
Current Occupation:					
Past Occupation(s) & periods:					

Patient's Name:

ALLERGIES

Please list your allergies to

Medications:

How did you react?

1.
2.
3.
4.
5.
6.

Food:

How did you react?

1.
2.
3.
4.

Others, eg IV dyes:

How did you react?

1.
2.
3.
4.

IMMUNIZATIONS

Children: Are you current? **No yes.** Please attach a copy of shots

Adults:

- Tetanus: no yes if yes,when was the last time?:
- Pneumovax: no yes if yes,when was the last time?:
- Influenza: no yes if yes,when was the last time?:
- Herpes Zoster: no yes if yes,when was the last time?:

Patient's name:

FAMILY HISTORY

	DOB	Medical/surgical illness,if any	Alive/Deceased	Cause of death if Deceased
Mother				
Father				
Siblings				
Males				
1.				
2.				
3.				
4.				
Females				
1.				
2.				
3.				
4.				
Children				
1.				
2.				
3.				
4.				
5.				

List any other significant family history

1.
2.
3.
4.
5.
6.

Patient's name:

REVIEW OF SYSTEMS

1. Constitutional

General good health lately	no	yes
Recent weight change	no	yes
Fever	no	yes
Fatigue	no	yes
Malaise	no	yes
Headache	no	yes

2

Eye disease or injury	no	yes
Wear glasses/contact lenses	no	yes
Blurred or double vision	no	yes
Eye irritation	no	yes
Drainage from eyes	no	yes
Seasonal eye symptoms	no	yes

3 Allergies

Runny nose	no	yes
Scratchy throat	no	yes
Itchy eyes	no	yes
Ear fullness	no	yes
Sinus congestion	no	yes
Stuffy nose	no	yes
Anosmia (not perceiving smell)	no	yes
Immunizations current	no	yes

4. Ears/Nose/Throat/Mouth

Hearing loss or ringing	no	yes
Earaches or drainage	no	yes
Puffing on ears R/L	no	yes
Chronic sinus problem or rhinitis	no	yes
Nose bleeds	no	yes
Mouth sore	no	yes
Bleeding gums	no	yes
Bad breath or taste	no	yes
Sore throat or voice change	no	yes
Swollen glands in neck	no	yes
Runny nose/congestion	no	yes
Sinus pressure/drainage	no	yes
Hearing well	no	yes

5. Cardiology

Heart trouble	no	yes
Chest pain or angina pectoris	no	yes
Palpitations	no	yes
Shortness of breath w/walking or lying flat	no	yes
Swelling of feet/ankles/face	no	yes
Dizziness	no	yes

6. Respiratory

Chronic or frequent cough	no	yes
Spitting up blood	no	yes
Shortness of breath	no	yes
Wheezing	no	yes

7. Gastroenterology

Loss or appetite	no	yes
Change in bowel movements	no	yes
Nausea or vomiting	no	yes
Frequent diarrhea	no	yes
Painful. bowel movements or constipation	no	yes
Rectal bleeding or blood in stool	no	yes
Abdominal pain	no	yes

8. Genitourinary

Cries while urinating	no	yes
Frequent urination	no	yes
Decreased urination	no	yes
Burning or painful urination	no	yes
Blood in urine	no	yes
Change force of stream urinating	no	yes
Incontinence or dribbling	no	yes
Kidney stones	no	yes
Recurrent UTI	no	yes
Sexual difficulty	no	yes
Male - testicle pain	no	yes
Male - difficulty with ejaculation	no	yes
Male - difficulty with erection	no	yes
Male - diminished sex drive	no	yes

Patient's name:

9. Integumentary (skin/breast)
Diaper rash no yes
Change in skin color no yes
Change in hair or nails no yes
Varicose veins no yes
Breast pain no yes
Breast lump no yes
Breast discharge no yes

10. Endocrinology
Glandular or hormone problem no yes
Excessive thirst or urination no yes
Excessive sweating no yes
Heat or cold intolerance no yes
Skin becoming dryer no yes
Change in hat or glove size no yes
Sleep disturbance no yes

11. Hematology/Lymphatic
Slow to heal after cuts no yes
Bleeding or bruising tendency no yes
Anemia no yes
Phlebitis no yes
Past transfusion no yes
Enlarged glands no yes

12. Musculoskeletal
Joint pain no yes
Joint stiffness or swelling no yes
Weakness of muscles or joints no yes
Muscle pain or cramps no yes
Back pain no yes
Cold extremities no yes
Difficulty in walkng no yes

13. Neuro
Frequent or recurring headaches no yes
Light-headed or dizzy no yes
Convulsions or seizures no yes
Numbness or tingling sensations no yes
Tremors no yes
Paralysis/weakness no yes
Head injury no yes
Memory loss or confusion no yes
Nervousness no yes
Depression no yes
Insomnia no yes
Steep disturbances no yes
Suicidal ideation/attempt no yes
Eating disorder no yes
Excessive anxiety or worry no yes
Find it difficult to control the worry no yes
Restless, feeling keyed up or on edge no yes
Easily fatigued no yes
Difficulty concentrating or mind going Blank no yes
Irritable no yes
muscle tension no yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in medical status. I also authorize the healthcare staff to perform the necessary treatment and services I may need which may include but are not limited to, laboratory procedures, x-ray examinations, diagnostic procedures, or medical or nursing treatments rendered to me under the general and special instructions of my physician.

This consent includes testing for blood-borne infectious diseases, including but not limited to hepatitis acquired immune deficiency syndrome (AIDS), and human immunodeficiency virus(HIV), if the physician orders such tests for diagnostic purposes.

Please initial: AGREE _____ DISAGREE _____

Signature of patient/parent/guardian: _____ Date: _____

Patient's name:

Frisco Urgent Care & Clinics

Consent for Medical Treatment

I, the undersigned, consent to the treatment and services which may include, but are not limited to, laboratory procedures, x-ray examinations, diagnostic procedures, or medical or nursing treatments rendered to me under the general and special instructions of my physician.

This consent includes testing for blood-borne infectious diseases, including but not limited to hepatitis acquired immune deficiency syndrome (AIDS), and human immunodeficiency virus (HIV), if the physician orders such tests for diagnostic purposes.

Please initial: AGREE _____ DISAGREE _____

Patient/Parent/Guardian Signature: _____ Date: _____

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: _____

Signature Page for the Financial Policy

Co-signature: If this Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date: Once you have signed this agreement acknowledging a copy of the Frisco Urgent Care & Clinic's Financial Policy was given to you, you agree to **all** of the terms and conditions contained therein and the agreement will be in full force and effect.

Patient's Name: _____

Responsible party (If not the patient):

Guarantor's Signature: _____ Date: _____

Co-Signature: _____ Date: _____