Shaker Urgent Care
MTP or GBG or DON

CHIEF COMPLAINT:

WC AUTO UC OCCUP BLOOD FP (Office Use Only)

PATIENT INFORMATION

Last Name _____ First Name _____ M _____

Date of Birth ___/___/___ Age _____ Sex ☐ M ☐ F Social Security # ___ — ___ — _____

Address _____ Apt # _____ City _____ State _____ Zip _____

Home Phone ( ) — Mobile ( ) — Preferred ☐ Home ☐ Mobile

Email _____ Race _____ Ethnicity _____ Preferred Language _____

Primary Care Physician _____ Phone ( ) —

In case of Emergency (Name, Phone, Relation) _____

Patient Employed By _____ Work Phone ( ) —

How did you hear about us? ☐ Billboard ☐ Drive By ☐ Email ☐ Facebook/Twitter ☐ Insurance ☐ Mailer ☐ Media ☐ School ☐ Webpage ☐ Word of Mouth

PARENT/GUARANTOR INFORMATION

Last Name _____ First Name _____ M _____

Date of Birth ___/___/___ Age _____ Sex ☐ M ☐ F Social Security # ___ — ___ — _____

Address _____ Apt # _____ City _____ State _____ Zip _____

Home Phone ( ) — Mobile ( ) — Preferred ☐ Home ☐ Mobile

Relation to Patient ☐ Parent ☐ Guardian ☐ Spouse ☐ Employer

PRIMARY INSURANCE

Insurance Carrier _____ Name _____ Sex ☐ M ☐ F

Subscriber ID _____ Group _____ Date of Birth ___/___/___ Relation _____

Address _____ Address _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

SECONDARY INSURANCE

Insurance Carrier _____ Name _____ Sex ☐ M ☐ F

Subscriber ID _____ Group _____ Date of Birth ___/___/___ Relation _____

Address _____ Address _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

AUTHORIZATIONANDRELEASE

By signing this consent form I acknowledge that I have read, understand, voluntarily consent to and authorize the following:

Authorization of Treatment: The administration and cost of all medical and surgical procedures, x-ray, and medication for myself and for my dependents.

Guarantee of Payment:

____Initial ☐ **SELF PAY** – I elect to pay for all services rendered in full today. I understand that my insurance will **NOT** be billed by Shaker Urgent Care.

____Initial ☐ **INSURANCE – Assignment of Benefits: I authorize payment directly to Shaker Urgent Care for all benefits otherwise payable to me. I also acknowledge that Shaker Urgent Care and Family Practice will submit my bill to my insurance carrier as a courtesy; however, I am responsible for all charg incurred.**

I agree that I will pay my estimated balance today based on the best available information of my current policy and Shaker Urgent Care's current contract with my insurance carrier. I understand this is only an estimate and after my visit is processed with my insurance company, I will be billed for any outstanding balance and/or refunded for any credit due to or by me. While Shaker Urgent Care makes every effort to verify my correct insurance information prior to leaving, I understand CEC cannot guarantee the accuracy of my bill until it has been fully processed by my insurance carrier and that I am ultimately responsible for all charges incurred.

Release of Medical Records: I authorize Shaker Urgent Care & Family Practice to release verbally, electronically, and/or in writing confidential medical information to any person or entity including my insurance carrier, employer (if treatment is related to employment), immediate family member (s), and/or other healthcare provider(s) for purposes of treatment, payment of charges, quality assurance and utilization review, transfer and follow-up procedures. I understand that should I choose not to release my medical record to a specific entity and/or person (s) I must specifically state so in writing to be kept in my medical record.

Receipt of Privacy Practices: By signing this consent form I acknowledge that a copy of the Notice of Privacy Practices of Complete Emergency Care is available to me upon request. I understand that a copy of this consent form may be used with the same effectiveness as the original.

Patient Signature _____ Date _____

SHAKER URGENT CARE AND FAMILY PRACTICE

_____GBG _____ MTP _____DON

Name of Primary Care Physician:_____

PATIENT NAME: _____ DATE OF BIRTH: _____
REASON FOR VISIT TODAY: _____

PATIENT HISTORY

Please mark an (x) by the conditions you may have or have had in the past:
_____Heart Disease _____Seizures _____None
_____High Blood Pressure _____Mental Health Problems
_____High Cholesterol _____Thyroid Disease
_____Diabetes _____Cancer (past or present)
_____Stroke Other_____

FAMILY HISTORY

PLEASE LIST CURRENT MEDICATIONS (include non-prescription products _____None
1)_____ 2) _____ 3) _____
4) _____ 5) _____ 6) _____
7) _____ 8) _____

PLEASE LIST ANY MEDICATIONS THAT YOU ARE ALLERGIC TO
_____None
1) _____ 2) _____ 3) _____
OTHER ALLERGIES _____(Foods, environmental, etc.) None_____

1) _____ 2) _____ 3) _____

Are you pregnant or breastfeeding: _____ Do you think you may be pregnant?_____
MAJOR SURGERIES _____None
1)_____ APPROX DATE _____
2)_____ APPROX DATE _____
3)_____ APPROX DATE _____

PERSONAL HABITS

1) Do you drink caffeinated beverages (coffee, tea, soda)? _____ Daily intake? _____
2) Do you drink alcoholic beverages? _____ If yes, _____ drinks/ _____ day,_____ week _____month
3) Do you smoke or chew tobacco? _____ If yes, _____/day, _____years of use

PHARMACY NAME: _____ **LOCATION**_____

SHAKER URGENT CARE AND FAMILY PRACTICE

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT FORM

Patient Name: _____ **Date of birth:** _____
(Please print)

Personal representative (if applicable): _____
(Please print)

I hereby acknowledge that Shaker Urgent Care has made available to me the Notice of Privacy Practices. Copies are available to me at any time and may be found in the waiting area, examination rooms or upon request.

Patient's Signature: _____ **Today's Date:** _____

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL INFORMATION TO THE FOLLOWING DOCTORS AND/OR INDIVIDUALS:

1. _____
2. _____
3. _____

Or

Personal Representative's Signature: _____ **Today's Date:** _____

Office Use:
On _____, I made a good faith attempt to obtain written acknowledgement of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to do so because of the following reason(s):

_____ *Patient (or personal representative) declined to sign the form.*

_____ *Patient (or personal representative) did not understand the request to sign the form.*

_____ *Other (specify)* _____

Employee Signature: _____ **Date:** _____

Eff. 6/9/14