PATIENT INFORMATION

Last Name:_________________First:____________________M.I.__________Sex:________

Social Security:__________________ Date Of Birth:______________________ Age:_______

Marital Status: _______________Race: ____________ Language: ______________________

Address: ____

City: _________________________ State:____________________ Zip Code: _____________

Home #: ___________________Cell #: ______________________Email:_________________

INSURANCE INFORMATION

Primary Insurance Plan:_________________ ID:____________________Group #____________

Policy Holders Last Name: _________________First Name: ______________DOB:___________

Social Security: ________________________ Phone#: _________________________________

Secondary Insurance Plan:_________________ ID:_______________ Group#_______________

Policy Holders Name:_____________________ First Name: _______________DOB:__________

Social Security: ________________________ Phone #: _________________________________

PHARMACY INFORMATION

Pharmacy Name:____

Phone Number:______________________ Fax Number:________________________________

Address or Major Cross Street:____

Patient (or Parent/Guardian) Signature:______________________________**Date:**___________

PATIENT HISTORY

Date:_________________

Patient Name:________________________________ DOB:______________________

Current Medications: (Name and Dosage)

____
____
____

Have you had any surgeries Yes____ No_____
Example; Gallbladder, Appendix, Hysterectomy, Vasectomy, Plastic Surgery, Tonsillitis, Heart Surgery
____Date ___________________________________

Are you allergic to any medications or food? If YES, please specify
____

Do you Smoke? Yes____ No_____ if yes, how often? ___________________
Do you Drink? Yes ____ No ______ if yes, how often? ___________________

Past Medical History	**Yourself**	**Family Members**	**Relationship**
Diabetes	Yes___ No___	Yes___ No___	_____________
High Blood Pressure	Yes___ No___	Yes___ No___	_____________
Asthma	Yes___ No___	Yes___ No___	_____________
Heart Disease	Yes__ vb _ No___	Yes___ No___	_____________
Abdominal pain	Yes___ No___	Yes___ No___	_____________
Anxiety	Yes___ No___	Yes___ No___	_____________
Chest Pain	Yes___ No___	Yes___ No___	_____________
Headache/Migraine	Yes___ No___	Yes___ No___	_____________
Osteoporosis	Yes___ No___	Yes___ No___	_____________
Pneumonia	Yes___ No___	Yes___ No___	_____________
Conjunctivitis	Yes___ No___	Yes___ No___	_____________
Bronchitis	Yes___ No___	Yes___ No___	_____________
Lung Disease	Yes___ No___	Yes___ No___	_____________
Cholesterol	Yes___ No___	Yes___ No___	_____________
Arthritis	Yes___ No___	Yes___ No___	_____________
Hepatitis	Yes___ No___	Yes___ No___	_____________

If other please explain:____

Women Only
How many pregnancies? _______
Miscarriages? __________

Men Only
Circumcised? Yes___ No___
Vasectomy? Yes___ No___

Abortions? ____________ Prostate Problems? Yes___ No___
Hysterectomy? Yes___ No_____

Authorization to Leave Detailed Messages

Including Voicemail, In-Person, or Other Authorized Forms of Communication
Adults (age 18>) Only

Incomplete or illegible forms will not be processed

Purpose: Allow Santa Rosa Urgent Care patients the opportunity to request or assign another adult individual(s) to receive detailed information about healthcare, treatment, insurance, billing or other information relevant to your healthcare at Santa Rosa Urgent Care.

Last Name (Print) First Name Date Of Birth

Address City State Zip Code

Authorization to Leave Detailed Telephone Messages

Including Voicemail, In-Person or Other Forms of Authorized Communication

This document authorizes Santa Rosa Urgent Care the right to leave detailed messages related to specific appointment information, normal test results, patient instructions, follow-up care descriptions, refill status, referrals or billing/insurance information.
Restrictions (if applicable):___________________________________

I hereby authorize Santa Rosa Urgent care to leave detailed messages at the following telephone numbers and/or with the following individuals:

For Contact with Me Personally:

Telephone #1: ___________________________ **Telephone #2:**_________________________

And/OR

For Contact With Another Adult Individual

Person #1

Last Name First Name Telephone # Relationship to Patient

Person #2

Last Name First Name Telephone # Relationship to Patient

Person #3

Last Name First Name Telephone # Relationship to Patient

Patient's Printed Name Patient's Authorized Signature Date of Signature

FINANCIAL POLICY

Thank you for choosing Santa Rosa Medical Center as your health care provider. We are committed to timely, successful and cost-efficient treatment of your health care needs. In order for us to maintain this high standard of health care, it is necessary for you to strictly adhere to financial policies. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to treatment.

Patient Information: All patients must complete our patient registration form prior to their initial office visit with the doctor. It is the patient's (and/or responsible party's) responsibility to keep this office informed of any changes in information (i.e. change of address, phone number, change of insurance, etc.) You will be required to update this information on an annual basis. ***Initial*____________**

Payment Information: payment is due at the time of the service. For your convenience we accept cash, Visa, and Master card credit and debit cards. Any co-pays you have with your insurance are you responsibility. They are dues and payable at time of the service. ***Initial:*_____________**

Insurance: As a courtesy to our patients, we will bill your insurance. In order to do so, we must have updated and accurate insurance information. Please be aware that your insurance policy is a contract between you and your insurance company. It is your responsibility to know your benefits. Your account with this office is your responsibility whether or not your insurance company pays. If your insurance company has not paid your account in full within 60 days, your account will become a "CASH" account with the balance due and payable immediately and prior to your next visit. ***Initial:*_____________**

Usual and Customary Rates: Our practice is committed to providing the highest standard of health care for our patients. We make every effort to align our fees with what is considered to be usual and customary for our area of specialty. ***Initial:*____________**

Minor Patients: The legal guardian of a minor patient is responsible for full payment of the account. Under no circumstances will we become involved in a domestic dispute. ***Initial:*____________**

Missed Appointments : Because our practice is extremely busy , please help us better serve you by keeping all scheduled appointments.

Collection Policy: I agree to be financially responsible for all charges incurred regardless of insurance coverage. In the event my account is referred to a collection service due to lack of payment on my part, I agree to pay all collection/legal fees that may be added to my account. If referred to collection service, I understand I will be discharged as a patient. I understand that id my bills are left unpaid for 90 days, it will be automatically sent to collections. ***Initial:*______________**

Returned Checks: There will be a $25.00 fee for all returned checks. If a check is returned, you will be expected to pay by cash or credit card for all the subsequent services.

I have read, understand and agree to the financial policy.

Patient (or Parent/Guardian) Signature: _____________________________**Date:**___________

HIPPA NOTICE OF PRIVACY PRACTICE

You have the right to request restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment, or healthcare operations. You may also request that any party of your protected health information not to be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of privacy practices. Your request must state the specific restrictions requested and whom you want the restriction to apply.

Your physician, is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit, use and disclosure or your protected health information, your health information will not be restricted. You then have the right to use another healthcare professional.

You have the right to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this from us, upon request, even if you have agreed to accept this notice alternatively (i.e. electronically)

You may have the right to have your physician amend and protect health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosure we have made. If any, or your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or the secretary of health services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate you for filling a complaint.

This notice has been published and become effective on/or before July 19, 2012.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protect health information. If you have any objections to this form, please ask to speak with our HIPPA compliance officer in person.

Signature below is only acknowledgment that you have received this notice of our policies.

Print Name:______________________________

Signature:________________________________

Date: ___________________________________