FAMILY MEDICAL • URGENT CARE

Welcome To Your Neighborhood Urgent Care & Family Medicine Clinic!

❐ **New Patient**
❐ **Patient Update**

REFFERAL SOURCE- How did you hear about us?

❐ Friend / Family ____________________ ❐ Other Doctor ________________ ❐ Attorney________________
❐ Previous patient ❐ Insurance Listing ❐ Walk In / Signage
❐ Website ❐ Other ____________________

PATIENT INFORMATION

Date_____/_____/______Patient Name____
(Last) (First) (Init.)

Date of Birth _____/______/_______ Age: ______________ Sex: M F

Social Security #__________________________ Marital Status: Single Married Divorced Widowed

Race: Decline American Indian/Alaska Native Asian Black/African American
Native Hawaiian/Other Pacific Islander White Other Race

Ethnic Group: Decline Hispanic/Latino Not Hispanic/Latino Language: _______________________

Address___________________________________City____________________ State_________ Zip Code__________

Home #_________________________Mobile #____________________________Work # ________________________

E-Mail:________________________________ Occupation ___________________ Employer _____________________

Emergency Contact______________________Relationship_________________ Phone # ______________________

Spouse Name __________________________Social Security #__________________ Date of Birth _____/_____/_____

Spouse Employer____ Phone #_______________________

INSURANCE INFORMATION

Primary Insurance: ____ Telephone # ____________________

Address ____________________________________City ___________________ State __________Zip_____________

Name of Policy Holder____ Date of Birth _______/______/______

Relationship to Patient_________________________Employer____

Member Id #_________________________________Group Id #_______________Social Security # ________________

Secondary Insurance: ____ Telephone # ____________________

Address ____________________________________City ___________________ State___________ Zip_____________

Name of Policy Holder ____ Date of Birth ______/______/_______

Relationship to Patient ________________________Employer____

Member Id #_________________________________Group Id #_______________Social Security # ________________

HEALTH SUMMARY

Problem List/Reason for Today's Visit: Please check ***ONE*** box (either Well visit, or Sick Visit)

Well Visit Health Check-Up/Establish Care

Please tell us when your last physical exam was ______________________ (month/date/year)

" Sick" Visit

Please allow the medical provider to address the **most** important symptom of concern. This will allow them to thoroughly evaluate, work-up and /or treat this chief concern accordingly.

Chief Complaint____

When did this start? ____________________________

Have you ever had any labs or testing associated with this concern? If yes, please list _________________________

____

Allergies: none

Allergy ___________________________ Reaction: _________________________

Allergy___________________________ Reaction: __________________________

Drug Allergies : No Known Drug Allergies

Drug___________________________ Reaction: _________________________

Drug___________________________ Reaction: _________________________

Drug___________________________ Reaction: _________________________

Drug___________________________ Reaction: _________________________

Preferred Pharmacy: ________________________________

Address/Cross Street __________________________________ Phone Number: ______________________

Current Medications:

Drug	Strength	Dosing (example: once a day)

Do you have any Advanced Directives? Living Will Do Not Resuscitate Power of Attorney Organ Donor

Other: ______________________________ Month/Year Directive(s) signed : ____________________________________

Past Medical History:

Medical Condition: _______________________________________ Month/Year Diagnosed ____________________

Medical Condition: _______________________________________ Month/Year Diagnosed ____________________

Medical Condition: _______________________________________ Month/Year Diagnosed ____________________

Medical Condition: _______________________________________ Month/Year Diagnosed ____________________

Medical Condition: _______________________________________ Month/Year Diagnosed ____________________

Medical Condition: ______________________________________ Month/Year Diagnosed ____________________

Other Medical Providers/Specialist:

Provider's Name: _____________________________________ Specialist:______________________________________

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Provider's Name: _____________________________________ Specialist:______________________________________

Preventive Health Maintenance:
Have you had any of these tests performed? If so, please indicate date of the most recent testing done and results.

*Boxes left empty will indicate test never performed or immunization never received.

Cardiac Testing		
Test	*Date Performed (month/year)*	*Results*
EKG		
Exercise Stress Test		
Stress Echocardiogram		
Nuclear Stress Test		
Echocardiogram		
Aortic Ultrasound		
Lower Extremity Arterial Ultrasound		
Carotid Doppler		
Pulmonary Testing		
Test	*Date Performed (month/year)*	*Results*
Chest X-Ray/ CT Chest		
Spirometry		

Diabetic Testing		
Test	*Date Performed (month/year)*	*Results*
Diabetic Monofilament Test		
Podiatric Evaluation		
Ophthalmologic/Retinal Eye Exam		
Labs for Diabetes (HgA1C, Urine Microalbumin)		
Gastrointestinal Testing		
Test	*Date Performed (month/year)*	*Results*
Endoscopy		
Colonoscopy		
FIT Testing (Cologaurd)		
Fecal Occult Guaiac Test		
Women's Health		
Test	*Date Performed (month/year)*	*Results*
Pap Smear		
Mammogram		
Bone Density Test		
Immunizations		
Vaccine	*Date Given (month/year)*	Name of Vaccination
Tetanus		
Pneumonia Vaccine		
Shingles Vaccine		
Flu Vaccine		
Miscellaneous Tests (i.e. sleep study, lead level, hearing test, allergy testing, ect)		
Test	Date Performed (month/year)	Results

Surgical History:

Surgery ______________________________ Date (month/year) ____________________

Surgery ______________________________ Date (month/year) ____________________

Surgery ______________________________ Date (month/year) ____________________

Family History: (diabetes, high blood pressure, high cholesterol, cancers, heart disease, ect)

Medical Condition	Which family member?

Social History:

Occupation:______________________________ Marital Status: ____________________________

Number of Children______________________ Other: ___________________________________

Tobacco/Alcohol/Supplements:

Do you use ANY tobacco products? NO YES

If YES, what type (ie cigars, cigarettes, chew, snuff ect) ________________________

past smoker, quit date: _______________ currently smokes ______cigs/day or _______ppd

drinks no alcohol rarely/occasionally drinks history of alcoholism currently alcoholic

Other: _____________________________________

Substance Abuse History: none

history of abusing: ________________________________ currently abuses: __________________________________

Mental Health History:

Mental Health Condition: _________________________________ Month/Year Diagnosed ____________________

Mental Health Condition: _________________________________ Month/Year Diagnosed ____________________

Mental Health Condition: _________________________________ Month/Year Diagnosed ____________________

Depression Screen?

1. Have you had little interest in doing things? no yes
2. Have you been feeling down or hopeless? no yes

If you answered yes to the question(s) above, how long have you been experiencing these symptoms? ______________

Any history of Communicable Diseases (i.e. STIs, or Tuberculosis)? ____

HIPPA/ INSURANCE AUTHORIZATION & RELEASE

HIPAA COMPLIANCE

- Your personal health information cannot be shared unless to prevent serious threat to your health or others.
- Your personal health information may be disclosed, if required to do so by law.
- You have the right to access your medical file and billing records.
- You have the right to request that we amend your information.
- You may revoke any written authorization given to us.
- All requests must be presented to this office in writing.

I allow my treatment/medical records to be released to:________________________Relationship___________________

INSURANCE ASSIGNMENT AND RELEASE

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to **SUNSET CLINIC.** I authorize **SUNSET CLINIC** to release any information required to process my claims. I understand it is my responsibility to make sure my account is paid by my insurance company. I have verified with my insurance company that **SUNSETCLINIC** is a participating provider. I understand that I am fully financially responsible if there are any unpaid claims by my insurance company for any reason.

Patient Signature: ____ Date: ____________________

NON-DISCRIMANATORY STATEMENT

Sunset Clinic does not discriminate based on age, ethnicity, race, religion or sex.
Sunset Clinic provides medical treatment based on patients needs and standards of care.

Patient Signature: ____ Date: ____________________