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**Patient Information**

**Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason for visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Patient Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI:\_\_\_\_

Gender: \_\_\_Male \_\_\_Female Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred method of Contact: home cell work

Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PCP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PCP Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Responsible Party Information:**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History Questionnaire**

**Family Illness**

Check if there is any history in your family of:

Diabetes:\_\_\_\_ High Blood Pressure:\_\_\_\_\_ Gout:\_\_\_\_ Stroke:\_\_\_\_ Alcoholism:\_\_\_\_ Asthma:\_\_\_\_ Cancer:\_\_\_\_ Heart Trouble:\_\_\_\_ Tuberculosis:\_\_\_\_ Psychiatric Illness:\_\_\_\_ Other:\_\_\_\_

Please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Statement of Present Health**

Do you take non-prescription drugs routinely? No Yes (specify)

Please specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take prescription drugs routinely? No Yes (specify)

Please specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take recreational drugs? No Yes

Date of last physical \_\_\_\_\_\_\_\_\_\_\_\_; Date of last hospitalization \_\_\_\_\_\_\_\_\_\_\_\_; No. of days \_\_\_

**Allergies:**

Please list any drug allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Random Urine Drug Screen:** All patients prescribed a controlled substance are subject to random urine drug screens as a part of this process, without exception, and without regard to age, sex, race, past medical history, or current diagnosis. These types of medications have potential for serious side effects, and also have potential for misuse, abuse and diversion. All results will remain a part of your medical record and used to guide your treatment.

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**Financial Consent:** I have read and understand the Patient Information for on the reverse side, and do hereby confirm that all the information I have provided is true and correct, to the best of my knowledge. I agree to notify Bradley Urgent Care in a timely manner of any changes to my health status, demographic, or insurance information.

I hereby acknowledge that I am ultimately responsible for the full payment of any and all fees for services provided to me. I authorize Bradley Urgent Care to furnish my insurance company all the information necessary to process claims in a timely manner. The filing of claims with any insurance carrier is a courtesy and does not in any way relieve me of financial responsibility for the cost of services rendered. A verification of benefits does not guarantee insurance payment. Insurance payment is based on the benefits that are in effect at time of service.

I understand that co-payments are due at time of service. I further agree to pay a $30 “return check” fee posted to my account as a result of the bank notifying this office of a “stop pay” or “non-sufficient funds” status.

**HIPAA:** I authorize the individual(s) below to have access to the following information contained in my records (Circle all that apply): MEDICAL FINANCIAL BOTH

You may revoke this authorization in writing at any time.

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_

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**If Patient is a Minor:**

I hereby authorize Bradley Urgent Care to administer medical care deemed necessary to minor child:

Name of Child:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Your Relationship to child:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize that the following person(s) have my consent to bring my child in for medical care and/or discuss their medical record.

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to child:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to child:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any additional information we should know:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The signature below represents a full understanding of the contents of this agreement and consent to receive treatment based on your Provider’s recommended plan of care.

**Patient’s Signature**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Legal Guardian’s Signature (if applicable):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**