PATIENT INFORMATION

Last Name: _____ First Name: _____M.I._____

Nick Name: _____ DOB: _____ Gender: _____ Marital Status: _____

Primary phone: _____-_____-_____ Secondary phone: _____-_____-_____

SSN: _____-_____-_____ Driver's License Number: _____

Mailing Address: _____

Physical Address: _____

Emergency Contact: _____ Phone: _____-_____-_____

Relationship to patient: _____

Email Address: _____

Primary Care Physician: _____ Phone: _____-_____-_____

Imaging Facility: _____ Phone: _____-_____-_____

Laboratory Name: _____ Phone: _____-_____-_____

Pharmacy Name: _____ Phone: _____-_____-_____

Insurance: _____ ID#: _____Group: _____

Policy Holder Name: _____ DOB: _____ Relation: _____

LEGAL GUARDIAN/ GUARANTOR INFORMATION

Last Name: _____ First Name: _____M.I._____

DOB: _____ Gender: _____ Relationship to patient: _____

Cell phone: _____-_____-_____ Home phone: _____-_____-_____

SSN: _____-_____-_____ Driver's License Number: _____

Mailing Address: _____

Physical Address: _____

PATIENT HEALTH INFORMATION

Reason for visit: _____

MEDICATIONS:

(list all prescribed or over the counter medications, supplements, or vitamins taken regularly or semi-regularly)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

ALLERGIES: _____

MEDICAL HISTORY:

(circle all current and past medical problems)

Anemia	Irritable bowel syndrome	Heart disease	Liver disease
Anxiety	Coronary Artery Disease	Hepatitis	Pulmonary Embolism
Arthritis	Deep Vein Thrombosis	High Cholesterol	Reflux/GERD
Asthma	Auto-immune Disease	Hypertension	Seizures/Epilepsy
Diabetes	Hyperthyroidism	Kidney stones	Depression
Gout	Hypothyroidism	Tuberculosis	Bleeding disorder
Stroke	Heart Attack	Kidney disease	Diverticulitis
COPD	Cardiac disease	Rectal Bleeding	Cancer

SURGICAL HISTORY:

(Please list all surgeries and the date of service)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

FAMILY HISTORY :

(List any history of the following conditions. Include relationship i.e. maternal grandmother, paternal grandmother)

Cancer: _____

Diabetes: _____

Heart Disease/Problems: _____

Bleeding Problems: _____

Respiratory Problems: _____

Problems with Anesthesia: _____

SOCIAL HISTORY:

Occupation: _____ Heavy lifting required?: _____Marital Status: _____

Previous Smoker?: _____ Current Smoker?: _____ How much in a day? _____ Years of use? _____

Do you drink Caffeine?: _____ How much?_____ How often?_____

Do you drink Alcohol?:_____ How much?_____ How often?_____

Previous Illicit Drug use?_____ Current Illicit Drug use?: _____

Marijuana use? _____ Chewing Tobacco?_____ Do you have an Advanced Directive? _____

AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Lincoln Urgent Care

Bre Howard, Privacy Officer

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) and California law, this practice may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and the purposes for the disclosure.

I hereby authorize this medical practice to use and disclose health information concerning:

Patient Full Name: _____ DOB: _____

This health information may be disclosed to:
(include last name, first name, and relationship to patient)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Please mark the type of records that may be disclosed:

_____ Any and all health information other than psychotherapy notes may be released, including, but not limited to, mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse records and/or HIV test results, if any, except as specifically provided below.

_____All psychotherapy notes may be released, except as specifically provided below:

_____Claims/Billing Records

_____Other: _____

The information may be used only for the following purposes (if you do not want to explain the purpose, write "At the request of the individual"):_____

"I understand that I may revoke this authorization at any time notifying this medical practice in writing. My revocation will not affect actions taken by this medical practice prior to its receipt."

"I understand that although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan or health care clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law."

"Effect of Refusal to Sign Authorization I understand that my health care treatment or benefits will not be affected whether I sign or do not sign this form. I understand that if I do not sign this form: A health plan may not enroll me or make me eligible for benefits. My physician will not perform the expert, employment, life insurance or other physical or medical evaluation which would otherwise be performed solely for the purpose of disclosure to a third party."

The authorization is in effect and will remain in effect until: _____

I understand that I have a right to receive a copy of this authorization upon request.

Signature: _____ Date: _____

Legal Guardian/Guarantor:

If not signed by the patient, please indicate the relationship: _____

Consent Financial and Office Policy

I understand my insurance policy is a contract between my insurance company and myself, and that I am ultimately responsible for the entire bill. The only exception to this is an approved workers compensation claim, and that should my works compensation status be reversed, that I am then responsible for the entire bill, I understand that the fees are based on treatment received and have no bearing on outcome. I understand that I may be asked for a deductible deposit every visit for any unmet deductible plans. I understand that LUC may, at its discretion, change the terms and conditions of this policy, and that I may request a copy of this policy at any time.

I hereby acknowledge I have received a copy of the Office policy and Financial Agreement.

Signature: _____ Date: _____

Authorization to Pay for Professional Services Rendered:

I hereby authorize payment directly to LUC of the benefits for professional services rendered, otherwise payable to me as determined by my insurance company, but not to exceed the fee as finally determined by my provider. I understand that I am financially responsible for any professional charges not paid by my insurance company to LUC.

I understand LUC's Professional Services Rendered Policy.

Signature: _____ Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices:

I hereby acknowledge I have received a copy of the Notice of Privacy Practices for LUC. I understand that LUC may, at its discretion, change the terms and conditions of this notice. I understand the content of the Notice of Privacy Practices and will be provided with a copy upon my request.

Signature: _____ Date: _____

Consent to Treatment:

I consent to general treatment, medical procedures, and medications prescribed by LUC.

Signature: _____ Date: _____