PATIENT INFORMATION:

Last Name: ________________________ First Name: ____________________________ Sex: (M / F)

DOB: ____/____/_______ Marital Status: _______ Email Address: ___________________________________

Address: ______________________________ City: ____________________ State: _______ ZIP: __________

Mailing Address (*If different from above*): ____

Home Phone: (_____) ______-___________ Cell: (_____) ______-____________ SSN: ______-____-_______

EMERGENCY CONTACT:

Name: ____ Relationship to patient: ________________________

Home Phone: (_____) ______-___________ Cell: (_____) ______-____________

PRIMARY CARE PHYSICIAN:

Primary Care Physician's Name: ________________________________ Phone: (_____) ______-___________

LEGAL GUARDIAN/ GUARANTOR INFORMATION: (if applicable)

Last Name: ________________________ First Name: ____________________________ Sex: (M / F)

DOB: _____/_____/__________ Cell: (_____) _______-________________ SSN: ______-____-___________

Relationship to patient: ____

Mailing address (*if different from patient's*): ____

MEDICATIONS: (please list all medications you are currently taking)

____ ____

____ ____

____ ____

SURGICAL HISTORY: (Please list all surgeries and the date of service)

____ ____

____ ____

____ ____

____ ____

ALLIERGIES: *(please state any allergies that you may have)*

____

MEDICAL HISTORY: (Please check all current and past medical history)

(Pediatric patients only) Are immunizations up to date? ☐ Yes ☐ No

☐ ***NONE***

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

☐ Other: ____

FAMILY HISTORY: (Please mark any history of the following conditions including relationship.)

	Mother	Father	Brother	Sister	Grandmother (Maternal / Paternal)	Grandfather (Maternal / Paternal)	Aunt (Maternal / Paternal)	Uncle (Maternal / Paternal)
Cancer								
Diabetes								
Heart Disease/Problems								
Bleeding Problems								
Respiratory Problems								

SOCIAL HISTORY:

Occupation: ____________________________ Do you have an Advanced Care Directive? ☐ Yes ☐ No

Use of nicotine products? ☐ Yes ☐ No *if marked yes, please state type of product (i.e. chew, cigarettes, vape, e-cigarettes, snuff*): ____________________________ Former user? ☐ Yes ☐ No *Years of Use*? ______________

Do you drink Caffeine? ☐Yes ☐No *if yes, how much?* ____________________ *How Often?* _______________

Do you drink Alcohol? ☐Yes ☐No *if marked yes, how much?* _______________ *How Often?*______________

Illicit Drug Use: ☐ Current ☐ Previous Marijuana Use: ☐ Yes ☐ No*?*______________

PATIENT HIPAA CONSENT FORM

In compliance with the Health Information Portability and Accountability Act of 1996 (HIPAA) and California law, Lincoln Urgent Care may not use or disclose your protected health information except as provided in our Notices of Privacy Practices without your authorization. Your completion of this form gives consent 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 Lincoln Urgent Care to use and disclose health information concerning:

Patient Full Name: ____ DOB: _________________

Health Information may be disclosed to:

Name (*first and last*): ______________________________________ Relationship:__________________________

Name (*first and last*): ______________________________________ Relationship:__________________________

Name (*first and last*): ______________________________________ Relationship:__________________________

Name (*first and last*): ______________________________________ Relationship:__________________________

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:

☐ At the request of the individual

☐ Other:____

"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."

“I understand that this form is only effective until one year after the date signed below.”

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: ________________