AUBURN URGENT CARE

Patient Information

Name: _____
Last **First** **Middle**

Date of Birth: _____/_____/_____

Social Security: _____

Permanent Address: _____

Apt #: _____ Zip:_____ City: _____ State: _____

Race: _____ Gender: M____ F ____ Undifferentiated _____

Home Phone: (_____)_____ Cell:(_____)_____

Marital Status: Single_____ Married_____ Widow_____ Divorced_____ Other_____

Employer: _____ Phone: (_____)_____

Employment Status: Full-time _____ Part-time _____ Other_____

Responsible Party: _____ Phone: (_____)_____

Do you want to opt in to the patient portal? Yes _____ No _____

If yes, E-Mail you wish to use _____

INSURANCE INFORMATION

PRIMARY Insurance Information

Primary Insurance Company Name
_____

Subscriber's Name as it appears on card
_____

Date of Birth _____/_____/_____

Contract or Policy # _____

Group # _____

SECONDARY Insurance Information

Secondary Insurance Company Name
_____

Subscriber's Name as it appears on card
_____

Date of Birth _____/_____/_____

Contract or Policy # _____

Group # _____

INSURANCE SUBSCRIBER'S INFORMATION

Name: _____
Last **First** **Middle**

Date of Birth: _____/_____/_____

Social Security: _____

Home Address: _____

Apt #: _____ Zip:_____ City: _____ State: _____

Race: _____ Gender: M____ F ____ Undifferentiated _____

Home Phone: (_____)_____ Cell:(_____)_____

Marital Status: Single_____ Married_____ Widow_____ Divorced_____ Other_____

Employer: _____ Phone: (_____)_____

Employment Status: Full-time _____ Part-time _____ Other_____

NON-COVERED SERVICES

As your physician, I want to provide you with the best care possible. There may be services that I feel are necessary for the treatment of your condition and maintenance of good health that are not covered by your health benefits contract. You are expected to pay for those services in full. Let me assure you that I will order only the test and treatments that I feel are necessary for your treatment and care. If you have any questions about whether or not a particular service is covered by your heath benefits contract, someone in our office will be happy to assist you. Thank you for your understanding.

I have read your policy and agree to pay for the services outlined that are not covered by my health benefits contract, possible non-covered services, and monies due.

Patient Signature: _____

Date: _____

CONSENT

I consent to treatment necessary for the above named patient.

I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable.

I authorize fax transmittal of my records, if necessary.

I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.

I agree to pay all reasonable collection costs in the event of default of payment of my charges.

I further authorize and request that insurance payments be made directly to Auburn Urgent Care should they elect to receive such payment.

I have read and fully understand that above consent for treatment, financial responsibility, release of medical information, insurance authorization, and non-covered services.

Patient Signature:_____

Date: _____

1. Name: **DATE:**

2. Social Security Number:

3. Date of Birth:

4. Marital Status: S___M___D___W___

5. What brings you to the office today?

Time of arrival:

6. Allergies to any medications? N___Y___

_____

7. Please list medications and dosage if you are taking any.

_____ _____

_____ _____

8. What is your occupation? _____

9. Do you smoke? Less than a pack ___or greater than a pack per day____?

10. Do you use alcohol? Daily _____or Occasionally_____?

11. Have you had surgery in the past? If so, list type and date.

_____ _____

_____ _____

12. Have you ever been pregnant? Please list number of pregnancies_____children_____

13. Have you had any fractures, joint problems, arthritis, or back problems? If so, please list them here along with the date of the problem:

_____

_____

Place a check mark only in the boxes that apply

CANCER	You	Father	Mother	Grandfather	Grandmother	Brother	Sister
Breast							
Uterine							
Prostate							
Colon							
Lung							
Leukemia							

GASTRO-INTESTINAL	You	Father	Mother	Grandfather	Grandmother	Brother	Sister
Hemorrhoids							
Peptic ulcer disease							
Chron's disease							
Diverticulitis							
Other							

RESPIRATORY	You	Father	Mother	Grandfather	Grandmother	Brother	Sister
Asthma							
COPD							
Tuberculosis							
Other							

HEMATOLOGY	You	Father	Mother	Grandfather	Grandmother	Brother	Sister
Anemia							
Gout							
Sickle Cell							
Lupus							
Osteoarthritis							
Other							

ENDOCRINE	You	Father	Mother	Grandfather	Grandmother	Brother	Sister
Diabetes Type 1							
Diabetes Type 2							
Thyroid							
Endometriosis							
Other							

GENTOURINARY	You	Father	Mother	Grandfather	Grandmother	Brother	Sister
Kidney Stones							
Other							

NEUROLOGICAL	You	Father	Mother	Grandfather	Grandmother	Brother	Sister
Alzheimer's							
Seizures							
Stroke							
Epilepsy							
Parkinson's							
Other							

PSYCHIATRIC	You	Father	Mother	Grandfather	Grandmother	Brother	Sister
Anxiety							
Depression							
Other							

CARDIOVASCULAR	You	Father	Mother	Grandfather	Grandmother	Brother	Sister
Heart Attack							
Congestive heart failure							
Coronary artery disease							
High blood pressure							
Other							

AUBURN URGENT CARE

1650A SOUTH COLLEGE STREET
AUBURN,AL 36830
ZENON BEDNARSKI,M.D. * V. MALAVONG, D.O. * MOSES JONES,M.D.

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Auburn Urgent Care to release medical information to the names listed below. This includes any spouse/ family member/ doctor's office that may call with questions about billing, records, prescriptions, etc. If a company sends you in for a drug screen, the company name MUST be listed on the lines below. If you do not wish to add anybody to your release, you MUST write "no one" on line one.

1._____

2._____

3._____

4._____

Patient's Signature: _____ **Date:**_____

Witness: _____ **Date:**_____

Patient Identifying Information:

Name:_____

Address:_____

Date of Birth:_____

Social Security Number:_____

Dr. Bednarski, Dr. Malavong and Dr. Jones are not responsible for any medical information disclosed by the third party to whom information is furnished under authorization.

PRIVACY PRACTICES ACKNOWLEDGEMENT

AUBURN URGENT CARE
1650 A SOUTH COLLEGE STREET
AUBURN,AL 36832

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Print Name: _____ Birthdate: _____

Signature:_____

Date:_____