PATIENT INFORMATION

INFORMATION TO BE FILLED OUT COMPLETELY

Patient Name: ____________________ , ____________________ Date of Birth: _________ Sex: ☐ Male ☐ Female
Last Name First Name

Address: ____ Apt # _______

City: ______________________ State: ________________ Zip Code: _____________

Home Phone: _________________ Cell Phone: __________________ Preferred Contact: ☐ Home ☐ Cell

Social Security Number: _______________ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Emergency Contact Information:

Name: ________________________________ Relationship: ____________________________

Phone Number: ____________________________ Date of Birth: _________________________

INSURANCE INFORMATION or SELF PAY

Primary Insurance:

Check One: ☐ Self Pay (no insurance) ☐ PPO ☐ HMO ☐ Medicare ☐ IEHP ☐ Other

If insured, complete the following:

☐ I, the patient, **AM** the Primary Subscriber for this insurance

☐ I, the patient, **AM NOT** the Primary Subscriber for this insurance

If **NOT** the Primary Subscriber, the Primary Subscriber for this insurance is: ______________________

Relationship to Primary Subscriber: _______________ Primary Subscriber's SSN#: __________________

Primary Subscriber's Date of Birth: _______________ Primary Subscriber's Phone #: _________________

Secondary Insurance: (if applicable)

Check One: ☐ PPO ☐ HMO ☐ Medicare ☐ IEHP ☐ Other

☐ I, the patient, **AM** the Primary Subscriber for this insurance

☐ I, the patient, **AM NOT** the Primary Subscriber for this insurance

If **NOT** the Primary Subscriber, the Primary Subscriber for this insurance is: ______________________

Relationship to Primary Subscriber: _______________ Primary Subscriber's SSN#: __________________

Primary Subscriber's Date of Birth: _______________ Primary Subscriber's Phone #: _________________

Authorization/Consent/Patient's Bill of Rights/Financial Policy

- I hereby consent to and authorize the administration of all diagnostic and therapeutic treatments that may be considered advisable or necessary in the judgment of the medical provider.
- I hereby authorize the medical provider to release any information acquired in the course of my examination or treatment as needed for payments or authorization for tests, procedures, referrals, or any other services deems medically necessary.
- I hereby authorize payment directly to the medical provider, of benefits otherwise payable to me, for services rendered.
- I have read and understand the practice's financial policy and agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice upon annual review and it is my responsibility to ask for updates.
- I have been offered, read, and understand the patient's bills of rights.

Print Name: ______________________________ **Relationship:** ____________________________
(Patient or Guardian) (if other than patient)

Signature: ____ **Date:** _________________
(Patient or Guardian)

If you have any questions regarding this notice of your health information privacy policies, please contact Temecula 24 hour Urgent care are 41715 Winchester Road, Suite 101, Temecula, CA 92590 Phone (951) 308-4451 Fax (951) 506-0992

MEDICAL QUESTIONNAIRE

IMMEDIATELY INFORM THE FRONT DESK IF YOU HAVE

***CHEST PAIN**
***SHORTNESS OF BREATH**
***SEVERE HEADACHE**
***LOSS OF CONSCIOUSNESS**
***ACUTE DISTRESS**
***LACERATIONS**

Patient Name: ________________________ , ________________________ Date of Birth: _______________
Last Name First Name mo/day/year

Reason for visit:

Duration of symptoms: __________________
(HOURS/DAYS/WEEKS/MONTHS)

Is this potentially a Legal Claim?: ☐Yes ☐ No Work Related Injury?: ☐Yes ☐ No Motor vehicle accident?: ☐Yes ☐ No

If you are here for a drug or alcohol screening ONLY, the below section is *optional*

Please check YES OR NO to symptoms that CURRENTLY apply to TODAY'S visit

Yes	No		Yes	No		Yes	No	
		Eye Pain			Abdominal pain			Neck pain or Stiffness
		Blurred or Double vision			Nausea or Vomiting			Lumps or swollen glands in neck
		Ear pain or Pressure			Painful bowel movements			Body aches
		Sore throat			Change in stool color			Back pain
		Cough			Frequent diarrhea			Loss of appetite
		Fever			Constipation			Irregular heartbeat
		Wheezing			Frequent urination			Light-headed or dizziness
		Painful breathing			Burning or painful urination			Rash or itching
		Difficulty swallowing			Change in urine color			Heartburn/GERD

Authorization/Consent

I hereby consent to and authorize the administration of all diagnostic and therapeutic treatments that may be considered advisable or necessary in the judgment of the medical provider. I hereby authorize the medical provider to release any information acquired in the course of my examination or treatment as needed for payments or authorizations for tests, procedures, referrals or any other services deemed medically necessary. I hereby authorize payment directly to the medical provider, of benefits otherwise payable to me, for service rendered. I have been offered, read, and understand the patient's bills of rights.

Print Name: ________________________________ **Relationship:** ______________________________
(Patient or Guardian) (if other than patient)

Signature: ____ **Date:** ____________________