PATIENT INFORMATION

INFORMATION TO BE FILLED OUT COMPLETELY

For office use only: Co-Pay/Pmt collected: $_______ Auth # _______

Patient Name: ______________________ , ______________________ Date of Birth: _________ Sex: ☐ Male ☐ Female
Last Name First Name
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Social Security Number: _______-_____-________
Address: ____ Apt # _______
City: ______________________________ State: __________________ Zip Code: ____________
Preferred Contact: ☐ Home ☐ Cell Home Phone: __________________ Cell Phone: __________________

Emergency Contact Information:
Name: ____ Phone Number: ________________________
Relationship: _________________________________ Date of Birth: __________________________

INSURANCE INFORMATION or SELF PAY

Primary Insurance: ☐ Self-Pay (no insurance)
☐ PPO ☐ HMO ☐ Medicare ☐ IEHP ☐ Other

If HMO Medical Group is: _______________

☐ 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
Name :____
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
Name :____
Relationship to Primary Subscriber: _________________
Primary Subscriber's Date of Birth: _________________
Primary Subscriber's SSN#: _________________________
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**

Reason for Today's Visit: Duration of symptoms: ________________ (HOURS/DAYS/WEEKS/MONTHS	Is this potentially a Legal Claim: ☐ Yes ☐ No Is this a work related injury: ☐ Yes ☐ No Is this a result from a motor vehicle accident: ☐ Yes ☐ No

Patient Name: ______________________, ______________________ Date of Birth: _____________ Age: ____
Last Name First Name mo/day/year

List Preferred Pharmacy : **Address:** **Phone:**

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

Yes	No	
		Eye Pain
		Blurred or Double Vision
		Ear Pain or Pressure
		Sore Throat
		Cough
		Fever
		Wheezing
		Painful Breathing
		Difficulty Swallowing

Yes	No	
		Abdominal Pain
		Nausea/Vomiting
		Painful Bowl Movements
		Change in Stool Color
		Frequent Diarrhea
		Constipation
		Frequent Urination
		Burning/Painful Urination
		Change in Urine Color

Yes	No	
		Neck Pain/Stiffness
		Lumps/Swollen Glands
		Body aches
		Back pain
		Loss of appetite
		Irregular heart beat
		Light-headed or dizziness
		Rash or itching
		Heartburn/ GERD

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Print Name: ____ **Relationship:** ________________________
(Patient or Guardian) (If other than patient)

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