Arrived:_____
Rec'd:_____
Roomed:_____
Notify:_____
Dr :_____

MRN:_____

Health Express Urgent Care Centers
REGISTRATION FORM
PATIENT DEMOGRAPHICS (PLEASE PRINT)

Patient Name:_____ SS#:_____ Date of Birth:_____

Race/Ethnicity:_____ Primary Care Physician:_____ Marital Status:_____ Sex: M/F

Street Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Consent to text: __ YES __ NO

E-mail Address:_____@_____
(Providing your E-mail will grant access to our Patient Portal)

Pharmacy Name/Location (RX will be sent to this location):_____

***REASON FOR YOUR VISIT:**_____
(If you are having CHEST PAIN you will be advised to go to the nearest ER)

Do you have allergies to any medications? ☐ No
☐ Yes (please list):_____

Do you have any medical conditions?

☐ HIGH BLOOD PRESSURE ☐ CAD/HEART ATTACK ☐ ARTHRITIS ☐ Hyper/Hypo-THYROIDISM
☐ KIDNEY DISEASE ☐ ASTHMA/COPD ☐ DIABETES ☐ OTHER:_____

Please list any medications you take regularly below (including over the counter medications and supplements):

1. _____ Dose _____ 4. _____ Dose_____
2. _____ Dose _____ 5. _____ Dose_____
3. _____ Dose _____ 6. _____ Dose_____

Hospitalization or Surgeries: _____
_____
_____

Possibility of pregnancy (if applicable) ☐ YES ☐ NO
If Injured, did this injury occur at work? ☐ YES ☐ NO

Emergency Contact:_____ Relationship:_____ Phone Number:_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Health Express Urgent Care Centers or insurance company to release any information required to process my claims.

X _____

_____ _____
Patient or Parent/Guardian Signature Date

MRN:_____

CONSENT TO TREATMENT:

I voluntarily consent to receive medical and health care services provided by Health Express Urgent Care's physicians, employees and such associates, assistants and other health care providers, as deemed necessary. I understand that such services may include diagnostic procedures, examinations, and treatment. I understand that this facility is a teaching institution and may have students involved in my care. I acknowledge that no warranty or guarantee has been made to me as a result or cure.

I acknowledge that this facility may use health information exchange systems to electronically transmit, receive and/or access my medical information which may include, but is not limited to, treatments, prescriptions, labs, medical and prescription history, and other health care information.

I understand that this Consent to Treatment/Health Care Agreement will be valid and remain in effect only for my visit today and the services provided during this visit.

RELEASE OF INFORMATION:

I acknowledge that "protected health information" pertains to my diagnosis and/or treatment at Health Express Urgent Care including, but not limited to, information concerning mental illness (except for psychotherapy notes), use of alcohol or drugs, or communicable diseases.

I authorize release of the following information: Health Express Urgent Care be permitted to the person(s) identified below *(NOT REQUIRED*):

NAME	**PHONE NUMBER**	**RELATIONSHIP**
_____	_____	_____
_____	_____	_____
_____	_____	_____

For a period not to exceed the date listed: _____/_____/ 20 _____

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS:

In consideration for health care services, I hereby assign to Health Express Urgent Care's physicians and providers my right, title, and interest in all insurance, Medicare/Medicaid, or other third-party payer benefits for medical or healthcare services otherwise payable to me. I also authorize direct payments to be made by Medicare/Medicaid and/or my insurance company or other third-party payer, up to the total amount of my medical and health care charges to Health Express Urgent Care's physicians. I certify that the information I have provided in connection with any application for payment by third-party payers, including Medicare/Medicaid, is correct.

I agree to pay all charges for medical and health care services not covered by, or which exceed, the amount estimated to be paid, or actually paid by Medicare/Medicaid, my insurance company, or other third-party payer, and agree to payment as requested by Health Express Urgent Care.

_____ _____

Print Name Relationship to Patient

X_____ _____/_____/_____

Signature Date

_____

Witness Signature (Staff)