Elite Urgent Care, LLC

PRIVACY POLICY HIPAA

Elite Urgent Care, LLC, Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our office may change. If we change our notice, you may obtain a revised copy from our front desk receptionist.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent in writing, except where we have already made disclosures in reliance on your prior consent. You also allow our office to contact you by phone or by mail to provide balance information, information about treatment alternatives, or other health benefits and services that may be of interest to you.

I,_____, give permission for Elite Urgent Care to discuss my care, appointment visits, and financial information with the following person(s):

Name	Relationship	Date of Birth
Name	Relationship	Date of Birth
Name	Relationship	Date of Birth

0 None

Primary Care Physician: _____ Telephone#_____

Specialist: _____ Telephone#_____

In case of emergency, I give permission to Elite Urgent Care to release my health information to a health care facility for further testing and/or treatment. (Please Check One) ☐ Yes ☐ No

_____ _____

Patient/Guardian Signature Date

Elite Urgent Care, LLC

Patient Medical History

Allergies	Reaction

Are you allergic or sensitive to any of the following? Latex O Iodine Adhesive Tape

CURRENT MEDICATIONS	DOSE	HOW OFTEN	REASON FOR MEDICATION

SURGICAL HISTORY	DATE

MEDICAL HISTORY (CHECK ANY CONDITIONS WHICH YOU HAVE BEEN OR ARE CURRENTLY BEING TREATED FOR}

0 *Alcoholism*
0 *Anemia*
0 *Anxiety*
0 *Depression*
0 *Diabetes (TYPE} _*
0 *Heart Disease*
0 *Heart Attack*
0 *High Blood Pressure*
0 *Kidney Disease*
0 *Asthma*
0 *Arthritis*
0 *Coronary Artery Disease*
0 *Cancer(TYPE) _____*
0 *GERO*
0 *High Cholesterol*
0 *Thyroid Disease (HYPO/ HYPER}*
0 *Ulcerative Colitis/Crohn's disease*

FAMILY HISTORY	**Relationship** (Mother, Father, Sibling, Grandparent)
0 Cancer Type:	
0 Anxiety/Depression	
0 Diabetes Type:	
0 Heart Disease	
0 High Blood Pressure	
0 High Cholesterol	
0 Kidney Disease	
0 Thyroid Disease	

SOCIALL HISTORY (CIRCLE ONE}
Marital status: Single/ Married/ Divorced / Widowed **Employment:** FT/ PT/ Unemployed/ Student
Sexually Active: YES/ NO
Tobacco Use: YES/ NO/ FORMER Alcohol Use: Social / Daily/ Never
Drug Use: NO/ Marijuana/ Cocaine/ Other:

I certify that to the best of my knowledge; the contents of this medical history are true and accurate. I authorize Elite Urgent Care, LLC, to enter **this information into my electronic chart for use in my medical care or as needed for my insurance carrier or other entity that might request my information.**

Patient Name: _____ Date: _____

Patient/Guardian Signature: _____

Elite Urgent Care, LLC

First Name:	Middle Initial:	Last Name:
Date of Birth:	Gender:	Social Security#:
Patient Home Address:	City, State, Zip:	Home#: Cell#: Okay to leave a message? ____Yes _____ **No`**
Email Address:		
How did you hear about our facility?		
Emergency Contact:	Relationship:	Contact#:
Legal Guardian (if under 18)	Relationship:	Contact#:
Is this due to a work-related injury: ____ **Yes** ____**No**	Is this due to an auto accident? ____ **Yes** ____**No**	Date of Accident or Injury:
Primary Insurance Name	Policy Holders Relationship to Patient: (Please Circle One) Self Spouse Parent Legal Guardian Other Subscriber DOB: _____ Social Security# _____	
Secondary Insurance Name	Policy Holders Relationship to Patient: (Please Circle One) Self Spouse Parent Legal Guardian Subscriber DOB:_____ Social Security# _____	
Pharmacy Name & Address:		

Elite Urgent Care, LLC

REASON FOR YOUR VISIT TODAY: _____

Please check off any symptoms you are experiencing TODAY ONLY!

GENERAL	ENT	EYE	Chest	GI	GU
☐**NONE**	☐**NONE**	☐**NONE**	☐ **NONE**	☐**NONE**	☐**NONE**
☐Fever	☐Sore throat	☐Double vision	☐Cough	☐Abdominal Pain	☐Painful urination
☐Wight gain	☐ Nasal drain	☐ Blurred vison	☐Wheezing	☐ Nausea	☐Frequency
☐ Weight loss	☐Sinus pain	☐ Eye redness (L/R)	☐Trouble breathing	☐Vomiting	☐Blood in urine
☐Fatigue	☐Congestion	☐Eye pain (L/R)	☐Chest Pain	☐Diarrhea	☐Difficult urination
☐Sleep disturbs	☐Facial pain		☐ Palpations	☐Black stools	☐Flank pain
	☐Ear pain (L/R)		☐Fainting	☐Blood stools	☐Incontinence

NEURO	SKIN	MUS/SKEL	HEMATO	ENDO	ALLERG/IMMUN
☐**NONE**	☐**NONE**	☐**NONE**	☐ **NONE**	☐**NONE**	☐**NONE**
☐Headache	☐Rash	☐Back pain	☐Bruise easily	☐Inc. appetite	☐Seasonal allergies
☐Trouble walking	☐ Itching	☐ Neck pain	☐Abnl bleeding	☐ Inc.thirst	☐TB/HEP
☐Blackout	☐Swelling	☐Joint pain	☐Anemia	☐Always hot	☐HIV+
☐Loss Strength		☐ Stiffness			☐Immunodeficiency
☐Diff speech		☐Knee pain			
☐Seizure		☐ Shoulder pain			
☐ Loss sensation		☐Arthritis			
☐ Confusion		☐Orthopedic disease			

ARE YOU A CURRENT SMOKER? YES / NO

PSYCH	SEXUAL/GENITALIA
☐ **NOE**	☐**NONE**
☐ Depression	☐Abnormal genital discharge
☐ Anxiety	☐Abnormal genital bleeding
☐ Suicidal	☐Abnormal genital bleeding
☐ Homicidal thoughts	

DATE OF LAST MESNTRYAL CYCLE:_____

BELOW FOR STAFF USE ONLY

UA Results:

BLD: **UBG:**
BIL: **PRO**
NIT: **KET:**
GLU: **PH:**
SG: **LEU:**
HCG:

BP	PULSE	RESPIRATIONS	TEMP	02%

HEIGHT	wight

*****Allergies***** **Current Medications** **Chief Complaint:** _____

Visual activity	R	L	B
Corrected?		Color V:	