Date: __________

Patient Label

Reason for Visit

Please write any symptoms you are having on the following lines:

____

____

Weight: _______ **Height:** _______ **Age:** _______ **Male** or **Female**

Is there a chance you could be pregnant?: Yes or **No** (any female between the ages of 8-80 seen for lower back pain, nausea, or abdominal pain who has not had a hysterectomy will have a pregnancy test)

Primary Care Doctor: ____

Medicine Allergies: ____

In case we need to call in a prescription, please provide a location or phone # for your pharmacy:

____

Check if you have any of the following health conditions:

Asthma	
COPD	
Seizures	
Kidney Problems	
Hepatitis	
Thyroid Disease	
Other	

Smoking	

Home #:

Heart Problems	
Diabetes	
Cancer	
Type of Cancer	
Stroke	
High Blood Pressure	
Autoimmune Disease	

If you checked "yes" or "other" above please explain:

____

____

Do you have a family history of: (circle) Hypertension COPD CAD Diabetes Other:

____

Past Surgical History: ____

Current Medications	

Patient Information

Name: ______________________________ SS#: ________________ Date of Birth: _______________

Mailing Address: ____

City State Zip

Home #: ____________________ Cell #: ________________ Male or Female

Email Address: ____________________________________ May we add you to our email list? Y or N

Employer: ____ Work #: ________________________

Emergency Contact Name: __________________________________ Phone #: ________________________

How did you hear about us? ____

Responsible Party for Patient

Name: ___________________ Relationship to Patient: ____________ Phone Number: _______________

Date of Birth: ____________ SS#: ______________ _ Mailing Address:______________________________

City:_______________________ State: ________ Zip Code: ____________

Insurance Information

Primary Insurance

Name of Insurance Company: ____

Name of Primary Insurance Card Holder: ________________________________Relationship to Patient: ____________

Primary Insurance Card Holder's **Date of Birth**: ________________________SS#: ________________________

If cards are not present please fill out the following information:

Contract/Member/Identification Number__________________________________ Group Number_______________

Claims Address (located on the back of the card) ____

Secondary Insurance

Name of Insurance Company: ____

Name of Secondary Insurance Card Holder: _______________________________ Relationship to Patient: __________

Primary Insurance Card Holder's **Date of Birth**: ________________________

SS# :_________________________

If cards are not present please fill out the following information:

Contract/Member/Identification Number__________________________________ Group Number_______________

Claims Address (located on the back of the card) ____

PLEASE READ CAREFULLY BEFORE SIGNING

Financial Obligation

It is your responsibility to inform the front desk of any and all updates to your insurance plan as well as your personal information. Failure to do so could result in charges becoming patient responsibility.

It is your responsibility to understand your insurance plan. Please make sure to contact your provider to determine if Greater Mobile Urgent Care is in network and covered under your plan. If we are not network providers and your insurance company has an out of

network deductible it will become patient responsibility. **Please be aware that you may be seen by a midlevel provider. You are responsible for verifying that midlevel providers (Physician's Assistant and Nurse Practitioners) are covered under your policy.**

You are responsible for the payment of charges for the health care that we provide. Unless your health insurance company, HMO or Medicare agreement with Greater Mobile Urgent Care, LLC prohibits it, payment is due at time of visit. Our office accepts cash, credit card and check payments. Patients that do not have benefits through a third party may speak with a front desk attendant regarding our fees.

By signing this document, I acknowledge that I am responsible for the financial obligation arising from the provision of care to myself, or the person for whom I am acting as a personal representative (such as an unemancipated minor). I acknowledge that I will incur the reasonable costs of collections including attorney's fee should I fail to satisfy my financial obligation. *There will be a rebilling fee of 30% of the total charges added to all accounts not paid in full within 90 days of service.*

HIPAA Privacy Notice

Greater Mobile Urgent Care requires a signed consent before sharing medical information with a third party. For exclusions to this policy, please ask a front desk staff member for a copy of our Notice of Privacy Practices. Details regarding the protection of patient privacy are detailed on that document.

There are times when Greater Mobile Urgent Care will need to contact you in order to provide you with lab work or X-ray results. We will also make a follow-up call a few days after your visit to see if we can be of any further assistance. If the phone number listed is not the number you would like us to use to contact you please list an alternate number here ____________________. If you would like to opt out of receiving a follow up call from us please check here_______. Otherwise, we will use the number provided to contact you. Thank you for your attention to this matter.

Injection / Testing Consent

Your physician will determine what treatment is most appropriate to address your symptoms and condition. We want you to be informed of all possible medications he/she may recommend and their potential side-effects. Please read and sign below to give your consent for injections. It is always your right as a patient to refuse treatment.

Medication	Potential Side-Effects
Kenalog, Decadron, Norflex Solumedrol, Toradol,	Discoloration of the skin, fat necrosis (dimpling of the skin at the injection site), headache, drowsiness, mood swings, flushing, increased appetite, allergic reaction.
Bicillin, Rocephin	Nausea, vomiting, diarrhea, allergic reaction.
Dilaudid*, Morphine*, Ativan	Dizziness, drowsiness, weakness, nausea/vomiting, blurred vision, allergic reaction.
Tetanus and Diptheria, B-12	Redness or arm soreness, mild flu-like symptoms, allergic reaction.
Compazine, Phenergan, Benadryl, Zofran	Dizziness, drowsiness, dry mouth, nausea, muscle jerking/agitation, allergic reaction.

I understand the potential risks of the above medications and consent to the recommended physician treatment.

Your physician will determine what tests are necessary to diagnose and treat you. It is always your right to refuse any recommended tests. If you are a female between the ages of 8 and 80 you may receive a pregnancy test. This is to ensure that appropriate treatment and medications are given.

× Patient Signature: ____

Date: ______________________

*If you receive one of these medications and must leave your vehicle at GMUC you will have 24 hours to remove it before it will be towed at owner's expense. Thank you!