

MEADOWBROOK URGENT CARE, P.C.

NAME: LAST _____ FIRST _____
 PATIENT PHONE NUMBER: _____ DATE OF BIRTH ____/____/____

***CHECK THE BOX NEXT TO THE SYMPTOMS YOU ARE EXPERIENCING FOR TODAY'S VISIT**

Constitution
<input type="checkbox"/> Chills
<input type="checkbox"/> Fatigue
<input type="checkbox"/> Fever
<input type="checkbox"/> Recent Weight Loss

Eyes
<input type="checkbox"/> Eye Itching
<input type="checkbox"/> Eye Matting/Discharge
<input type="checkbox"/> Eye Pain
<input type="checkbox"/> Eyelid Redness
<input type="checkbox"/> Vision Changes

Ent/Mouth
<input type="checkbox"/> Ear Drainage
<input type="checkbox"/> Ear Pain/Pressure
<input type="checkbox"/> Hearing Loss
<input type="checkbox"/> Hoarseness
<input type="checkbox"/> Popping of Ears
<input type="checkbox"/> Post-nasal Drip
<input type="checkbox"/> Sinus Pressure/Drainage
<input type="checkbox"/> Sore Throat
<input type="checkbox"/> Stuffy Nose
<input type="checkbox"/> Tinnitus (Ear Ringing)
<input type="checkbox"/> Toothache

Abdominal Issues
<input type="checkbox"/> Abdominal Pain
<input type="checkbox"/> Bloating
<input type="checkbox"/> Constipation
<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Gas/Indigestion
<input type="checkbox"/> Nausea/Vomiting
<input type="checkbox"/> Rectal Bleeding
<input type="checkbox"/> Rectal Pain

GU
<input type="checkbox"/> Blood in Urine
<input type="checkbox"/> History of STD's
<input type="checkbox"/> Painful Urination
<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Urinary Frequency
<input type="checkbox"/> Vaginal Discharge

Muscular/Skeletal
<input type="checkbox"/> Back Pain
<input type="checkbox"/> Joint Pain
<input type="checkbox"/> Muscle Aches
<input type="checkbox"/> Muscle Spasm
<input type="checkbox"/> Neck Pain
<input type="checkbox"/> Extremity Swelling

Blood
<input type="checkbox"/> Bleeding
<input type="checkbox"/> Easy Bruising
<input type="checkbox"/> Painful/Swollen Lym

Allergy/Immunization
<input type="checkbox"/> Allergies
<input type="checkbox"/> Hay Fever/Sneezing
<input type="checkbox"/> Hives
<input type="checkbox"/> Recurring Infections

Skin/Breast
<input type="checkbox"/> Bites/Sores
<input type="checkbox"/> Breast Lump
<input type="checkbox"/> Color Change
<input type="checkbox"/> Itch
<input type="checkbox"/> Lesion

Psych
<input type="checkbox"/> Anxiety
<input type="checkbox"/> Depression
<input type="checkbox"/> Insomnia

Neurology
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Headache
<input type="checkbox"/> Loss Consciousness
<input type="checkbox"/> Muscle Weakness
<input type="checkbox"/> Numbness/Tingling
<input type="checkbox"/> Paralysis/paressis
<input type="checkbox"/> Poor Balance
<input type="checkbox"/> Speech Difficulties

Respiration
<input type="checkbox"/> Cough
<input type="checkbox"/> Coughing Blood
<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Wheezing

Cardio
<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Palpitations
<input type="checkbox"/> Shortness of Breath

OTHER _____

CURRENT MEDICATIONS

REASON FOR TODAY'S VISIT

Return visit: Condition is: ___worse ___same

PHARMACY NAME & PHONE NUMBER _____

PRIMARY CARE DOCTOR & PHONE NUMBER _____

PARENT/LEGAL GUARDIAN

(Our office policy is that this the parent who BRINGS the child to the visit is the responsible party)

NAME: LAST _____ FIRST _____ MI _____

DATE OF BIRTH: ____/____/____ SOCIAL SECURITY# ____/____/____ SEX: ___M ___F

RELATIONSHIP TO PATIENT: _____

Check box if address is the same as patient address

CURRENT ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____ HOME PHONE: (____) _____

X _____
SIGNATURE OF PATIENT/GUARDIAN

DATE

MEADOWBROOK URGENT CARE, P.C.
GENERAL CONSENT TO TREATMENT FORM

(Please read carefully before signing)

1. Consent to Testing and Treatment

I voluntarily consent to urgent care which may include a complete medical history, physical examination, routine diagnostic procedures, and such medical treatment as is deemed necessary and appropriate by the physician, physician assistant and/or associates at Meadowbrook Urgent Care, P.C.

I understand and agree that in the very rare event that a health care provider at Meadowbrook Urgent Care, P.C. sustains a significant exposure to my blood and/or bodily fluids that Meadowbrook Urgent Care, P.C., may have laboratory studies performed on my blood to detect the presence of a potentially serious incubating communicable disease, such as hepatitis or AIDS. The result of any such test will be treated confidentially.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantee or promise has been made to me as to the results of the care and treatment which I have hereby authorized.

I authorize Meadowbrook Urgent Care, P.C. to dispose of any specimen or tissue remaining after completion of a clinical procedure or treatment.

2. Acknowledgment of Notice of Privacy Practices and Release of Medical Record Information

I acknowledge that I was offered and/or provided the Meadowbrook Urgent Care, P.C., Notice of Privacy Practices, and that I may obtain an additional copy of the Notice at any time. This Notice describes how Meadowbrook Urgent Care, P.C., uses and discloses medical information in accordance with the protections of the law.

I authorize Meadowbrook Urgent Care, P.C., to release pertinent information and/or copies of medical records of any information protected under the regulations in 42 Code of Federal Regulations, Part 2, if any, psychiatric/psychological/substance abuse/service records, if any, social work records, if any, including communications made to me by a social worker or psychiatrist/psychologist and any information about Human Immunodeficiency Syndrome (AIDS) to other institutions, physicians, third party payers, insurance companies or review agencies for use in connection with my care. I acknowledge that medical record information may be released to my employer if this is a work-related examination or injury for which a workers compensation claim has been filed.

3. Authorization for Payment

I assign and authorize payment directly to Meadowbrook Urgent Care, P.C., for any and all services rendered. I understand that I am financially responsible for services that may not be covered under my health insurance policy. I understand that it is my responsibility to pay, at the time of discharge, or on an interim basis as arranged with Meadowbrook Urgent Care, P.C., in accordance with its Payment for Services Policy (dated April 21, 2014) a copy of which I acknowledge that I have received, for all charges not covered by my insurance company, such as but not limited to deductibles and co-payments.

MEADOWBROOK URGENT CARE, P.C.
GENERAL CONSENT TO TREATMENT FORM -- continued

(Please read carefully before signing)

4. Additional Acknowledgements

I understand that Meadowbrook Urgent Care, P.C., and/or its business associates, may contact me by telephone at any telephone number provided by me or associated with my record, including cell phone numbers, which could result in telephone company charges to me. Meadowbrook Urgent Care, P.C., may also contact me by sending text messages or e-mail messages using the contact information I provide. Methods of contact may include using pre-recorded/synthetic voice messages and/or use of an automatic dialing device, if, when or as applicable.

I hereby release Meadowbrook Urgent Care, P.C., from responsibility for all personal articles which I have with me now and will have during my time as a patient at your urgent care facility. I understand that Meadowbrook Urgent Care, P.C., is not responsible for clothing, spectacles, dentures, money, personal electronic devices or other personal articles of value kept in my possession or anywhere on the premises during my time as a patient at your urgent care facility.

Authorizing Signatures

THE PURPOSE OF THIS FORM WAS EXPLAINED TO ME AND I HAD THE OPPORTUNITY TO ASK QUESTIONS.

Signature of Patient	Date	Time
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Signature of Witness	Date	Time
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If patient is unable to consent or is a minor, please complete the following:

**Patient is a minor _____ years of age or patient is
unable to consent because _____**

Signature of Parent, Legal Guardian or Closest Relative	Date	Time
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Signature of Witness	Date	Time
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