Patient Information

Thank you for choosing our office! In order to serve you properly, we need the following information. Please print. All information will be confidential.

Patient Full Name: ____ Sex: M / F Date of Birth: _______________

SSN: __________________ Email: ___________________________________ Primary Phone #:_______________________

Address: ______________________________ City: ____________________ State: ______ Zip: _______________________

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Patient's Employer: ___________________________________Work Phone: _______________________________

Business Address: ______________________________ City: _______________ State: ______ Zip: ______________________

Emergency Contact**:** ___________________________ Phone #: __________________ Relationship: _____________________

Other Patient Information

Which racial category does the patient most identify with?

☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic

☐ Native American ☐ Native Hawaiian ☐Pacific Islander ☐ Other: ___________________ (please specify)

What is the patient's ethnicity? ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Preferred Name/Pronouns: ____

Complete If Patient Is a Minor

Parent/Guardian Name: ____ Relationship: ________________

Parent/Guardian Name: ____ Relationship: ________________

Primary Insurance Information

Name of Insured: _____________________________ Relationship to Patient: _________________________

Policy Holder Date of Birth: ____________________ Policy Holder SSN: __________________________

Name of Employer: _________________________________ Work Phone: ______________________________

Address of Employer: __________________________________ State: __________ Zip: __________________

Insurance Company: _____________________ ID #: ____________________________ Group #: ________________________

Secondary Insurance Information

Name of Insured: ___________________________ Relationship to Patient: ___________________________

Date of Birth: ___________________ SSN: ___________________________

Insurance Company: _____________________ ID#: ______________________ Group #: ______________________________

Patient History

Patient Name: ____ DOB: ___/___/___
Primary Care Physician's Name: ______________________________ Date of Last Exam: ___ / ___ /___

Please leave a brief description of reason for office visit today:

____

Please list any previous surgeries/hospitalizations with the dates they occurred:

____
____

Please list any allergies (medication and seasonal):

____
____

Please list your daily medications below, including name of medication and dosage:

____
____

From which pharmacy do you get your medications? (please include name and street address)

____

Please place an "X" in the box corresponding to conditions/ailments for which you are currently being treated or have a history of:

☐ Heart Disease (Coronary Artery Disease) ☐ High Blood Pressure (Hypertension) ☐ High Cholesterol
☐ Acid Reflux (GERD) ☐ Chronic Cough ☐ COPD
☐ Chronic Headaches/Migraines ☐ Asthma ☐ Seasonal Allergies
☐ Low Blood Pressure (Hypotension) ☐ Glaucoma ☐ Hepatitis
☐ Depression/Anxiety ☐ Diabetes (please circle type): I / II ☐ Epilepsy/Seizures
☐ Arthritis (please circle type): RA / OA ☐ Tonsillitis ☐ Anemia
☐ HIV/AIDS ☐ Stroke ☐ Cancer
☐ Ulcers ☐ Low Thyroid ☐ High Thyroid
☐ Irregular Heart Beat ☐ Shortness of Breath ☐ Leg/Ankle Swelling
☐ Congestive Heart Failure ☐ Chronic Constipation ☐ Dark Stools
☐ Back Pain ☐ Malaise/General Fatigue ☐ Frequent UTIs

Please list any other medical history not included above:

____

Females: Date of Last Menstrual Period: _______________ ☐ Menopausal Last Pap (mo/yr): ___ / ___
Last Mammogram (mo/yr): ___ / ___ No. of Pregnancies: ____ No. of children: ____

Social History

Do you drink caffeine? ☐ Yes ☐ No Cups/day: ___
Do you use tobacco? ☐ Cigarettes ☐ Smokeless tobacco Cigarettes/day: ____
If you have quit smoking, how long did you smoke? ____ years How long ago did you quit? ____
Do you currently use alcohol regularly? ☐ Yes, currently ☐ No, not regularly Drinks/week: _____
Do you currently use or have history of drug use? ☐ Yes, currently ☐ Yes, history ☐ No
If yes, please specify: ☐ IV ☐ Opioids ☐ Methamphetamine ☐ Cocaine ☐ Prescription
☐ Marijuana ☐ Other: _________________
Are you sexually active? ☐ Yes ☐ No
Are you currently on birth control? ☐ Yes ☐ No If yes, what kind? ________________________

Family History

Patient Name: _________________________________ DOB: ___ / ___ / ___

If known, please complete the following about your blood relatives.

Are you adopted? ☐ Yes ☐ No

Father: ☐ Do not know
☐ Alive
☐ Deceased + age of death: _______
Cause of Death: ________________

Mother: ☐ Do not know
☐ Alive
☐ Deceased + age of death: _______
Cause of Death: ________________

No. of Brothers: ________
No. of Sons: ___________
No. of Sisters: ___________
No. of Daughters: ________

To help us understand any special circumstances for your family, we need to know if you or any of your family has had any of the following. Please check the appropriate boxes. Identify all illnesses or conditions which you know have occurred in you or your blood relatives. Indicate "None" if you are unsure.

Condition	Father	Mother	Brothers	Sisters	Sons	Daughters	Grandparents	None
Anemia								
Cancer								
Diabetes								
Glaucoma								
Heart Disease								
High Blood Pressure								
HIV/AIDS								
Anxiety/Depression								
Stroke								
Asthma								
Migraines								
Congestive Heart Failure								
High cholesterol								
Seizure Disorder								

Please specify any other family history not included above:

____

____

____

Patient Authorization

Patient Name: _______________________________________ DOB: ___/___/___

Under the Health Insurance Portability and Accountability Act (HIPPA), you are entitled to privacy regarding your protected health information. By initialing below, you authorize Allied Medical and Urgent Care to disclose/use all your protected health information for specific and special purposes related to your medical care. Further, you authorize Allied Medical and Urgent Care to release protected health information to HIPPA – covered entities on your behalf, including health insurance plans, providers, healthcare clearinghouses, and others.

Please initial: _______

I authorize Allied Medical and Urgent Care to leave a detailed message regarding my health care treatment to the phone number(s) below:

☐ Check this box if you do not want us to leave a message regarding your health information.

Primary Phone #: _____________________ Secondary Phone #: ___________________

Please initial: _______

I authorize Allied Medical and Urgent Care to communicate verbally with the following individuals regarding appointments, test results, and general health information:

Name: ______________________________ Relationship: ____________________ Phone #: ______________________

Other Name: _________________________ Relationship: ____________________ Phone #: ______________________

Please initial: _______

I authorize Allied Medical and Urgent Care to release any medical information needed to determine payment for my services. I understand that without this particular authorization, AMUC cannot file claims to my insurance, and I will personally pay at the time of service for all medical services.

Please initial: _______

I authorize my insurance carrier to make direct payments on my behalf to AMUC for medical services.

Please initial: _______

I am aware that I am responsible for all co-pays, co-insurance, or any deductibles at the time of service.

Please Initial: _______

____ **Date: ____________________**

Signature of Patient (or Legal Representative)

Please note: This authorization can be revoked at any time by written notice to Allied Medical and Urgent Care. Any revocation will become effective the date received by the office. This authorization does not limit the treatment available to me; it only affects the use of my medical information. Redisclosure of my health information by a HIPPA-covered entity receiving the information may occur.

Authorization for Release of Information

I hereby authorize ____

(Facility from Where Records Need to be Requested)

____

(Full and Complete Address)

____

(Phone Number and Fax Number)

To disclose my individual identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), mental illness (except psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history treatment, or any other such related information. I understand that this authorization is voluntary, and I may refuse to sign authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or a health care provider, the released information may no longer be protected by federal and state privacy regulations.

______________________ ______________________ ______________________

Print Patient Name Date of Birth Social Security Number

Date(s) of Service (if known): ______________________ or circle: ALL DATES OF SERVICE

Description of Information to be released: (check all that apply)

☐ Emergency ☐ Radiology Reports ☐ Admission/Registration Records
☐ History & Physical ☐ Consultant Reports ☐ Laboratory Reports
☐ Nursing Notes ☐ Physician's Report ☐ Billing Records
☐ Progress Notes ☐ Operative Records ☐ Other:______________________
☐ Discharge Summary ☐ Radiology films

Description of the purpose of the use and/ or disclosure:

____
____
____

The health information described herein shall be released to:

☐ Hospital ☐ Physician ☐ Insurance Company ☐ Attorney ☐ Patient ☐ Other_______________

Records should be sent to:

Allied Medical and Urgent Care
1501 N. Elm St.
Denton, TX 76201
Phone (940) 387-0019
Fax (855) 392-5987

I understand that this authorization will expire by law 180 days from the date of the authorization unless I otherwise specify. I desire this authorization to be in effect until _______________. I further understand that I may revoke this authorization at any time by notifying____________________ in writing at ________________________________. I also understand the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

______________________________ ______________________

Signature of Patient (or Legal Representative) Date

Patient Name: ______________________________________ DOB: ___/___/___

Financial Agreement

I hereby assign all medical and/or surgical benefits, to include all major medical benefits to which I am entitled from private insurance or any other health plan, to Allied Medical and Urgent Care of Denton.
I agree to pay all balances due to AMUC after all co-pays, coinsurance, insurance payments, and discounts have been applied to my account, including my yearly deductible, if any. I understand that any claims denied by my insurance will be my responsibility. I authorize AMUC to release any and all information to my insurance company to secure payment.
I understand that treatments and procedures will be explained orally and prior to my receiving them. I agree to accept the treatments and procedures as deemed medically necessary, and I have the right to refuse treatment at the time of service.

____ Date: ___________________

Signature of Patient (or Legal Representative)

Consent for Treatment

I hereby represent that I am over the age of 18 or that I am the parent/legal guardian of the patient being treated. Misrepresenting my age or my legal guardianship of the patient may violate federal and state health privacy laws. Further, by signing this form, I represent that any consent or form signed by myself or the minor has the consent of all interested parties involved in the care of the minor.
I hereby consent to medical treatment by Allied Medical and Urgent Care and any other services rendered during my visit. Services include physical exams, diagnostic testing such as lab draws, injections, IV hydration, and minor procedures.
In order to ensure that you understand all aspects of your visit, you are encouraged to ask any questions or clarify any procedures prior to them being performed. You may withdrawal consent to a procedure at any time.

____ Date: ___________________

Signature of Patient (or Legal Representative)

Missed Appointment Policy

Our policy is to charge $25 for missed appointments not cancelled within 24 hours of the appointment time. This policy applies to new and established patients and will be charged to the patient/guarantor, not the insurance. All no-show fees must be paid prior to the next appointment in order to be seen. Allied Medical and Urgent Care reserves the right to terminate the doctor-patient relationship of established patients due to no-shows. New patients who no-show will be billed the no-show fee and will not be scheduled again until the fee has been paid. Please help us to serve you better by keeping your regularly scheduled appointment.
I have read and understand the No-Show policy and agree to abide by the terms:

____ Date: ___________________

Signature of Patient (or Legal Representative)

Patient Name: ______________________________ DOB: ___/___/___

Telemedicine Consent

Estimated Patient Financial Responsibility: Telemedicine visit charges are billed and collected in the same manner as regular in-office visit and estimated patient responsibility will be due prior to the start of the Telemedicine encounter. Final patient responsibility will be determined after charges are filed and processed by your insurance carrier(s).

Purpose: The purpose of this form is to obtain your consent for a Telemedicine visit with your provider at Allied Medical and Urgent Care of Denton. The purpose of this visit is to help in your medical care.

Privacy: All information given at your Telemedicine visit will be maintained by the doctors, other health care providers, and health care facilities involved in your care and will be protected by federal and state privacy laws.

Your Rights: You may opt out of the Telemedicine visit at any time. This will not change your right to future care or health benefits.

Waiver/Release: By signing below, you understand and agree that you solely assume the risk of any errors or deficiencies in the electronic transmission of information during your Telemedicine visit or in the electronic submission of your images to your provider and further understand that no warranty or guarantee has been made to you concerning any particular result related to your condition or diagnosis. To the extent permitted by law, you also agree to waive and release you provider and his/her institution or practice from any claims you may have about this advice or the telehealth visit generally. The consent provided in this document will expire in one year from the date you sign it, but your waiver and release shall apply indefinitely for any Telemedicine visits that occur during the one-year period after your signature date.

____ Date: ___________________

Signature of Patient (or Legal Representative)