Evans Urgent Care | Dr. Brett K. Wallentine, MD | 800 Oakhurst Drive Evans, GA 30809 | (706)364-5500

Date: ____/____/____

Existing Patient Updated Information

___________________________ ________ _______________________________ ________________________

First Name MI Last Name Prefer to be called (Nickname)

______________________________________ ______________________________ _______ __________________

Street City State ZIP

(______) ______-__________ (______) ______-__________ (______) ______-__________

Home Telephone Work Telephone Cell Phone

_____/_____/_____ M F _________-________-_____________

Birthday Gender SSN

Please check one: ☐Married ☐Single ☐Divorced ☐Widowed ☐Legally Separated

Race: ☐Asian ☐Black/African American ☐Native American ☐White ☐Prefer Not to Answer

______________________________________ ____

Employer Occupation

What Pharmacy Do You Use? Name: ______________________________ Location: _____________________________

Responsible Party

If the patient is a minor or otherwise not financially responsible for payment, please provide the following information regarding the person who is responsible. This is not your insurance company.

___________________________ ________ _______________________________ ________________________

First Name MI Last Name Prefer to be called (Nickname)

______________________________________ ______________________________ _______ __________________

Street City State ZIP

(______) ______-__________ (______) ______-__________ (______) ______-__________

Home Telephone Work Telephone Cell Phone

_____/_____/_____ M F _________-________-_____________

Birthday Gender SSN

_______________________________ _______________________________ _______________________________

Relationship to patient Guardian's Employer Occupation

PLEASE TURN THE PAGE OVER TO COMPLETE

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Emergency Contact

____ ___________________________________
Name: (FIRST) (MI) (LAST) Relationship

(_____) _____-__________ (_____) _____-__________ (_____) _____-__________
Home Telephone Work Telephone Cell Telephone

Primary Insurance

____
Insurance Company

_________________________ ________ _____________________________ _______________________
Policy Holder First Name MI Last Name Relationship to Patient

____________________________________ ____________________________ ______ _________________
Street City State ZIP

(______) ______-__________ (______) ______-__________ (______) ______-__________
Home Telephone Work Telephone Cell Phone

_____/_____/_____ M F _________-________-_____________
Birthday Gender SSN

Secondary Insurance (if any)

____
Insurance Company

_________________________ ________ _____________________________ _______________________
Policy Holder First Name MI Last Name Relationship to Patient

____________________________________ ____________________________ ______ _________________
Street City State ZIP

(______) ______-__________ (______) ______-__________ (______) ______-__________
Home Telephone Work Telephone Cell Phone

_____/_____/_____ M F _________-________-_____________
Birthday Gender SSN

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Evans Urgent Care
FAMILY MEDICINE

Evans Urgent Care | Dr. Brett K. Wallentine, MD | 800 Oakhurst Drive Evans, GA 30809 | (706)364-5500

MEDICAL HISTORY

Patient Name: ______________________________ Date of Birth: _____/_____/_____ Today's Date: ____/____/____

Do you or have you had any of the following conditions? Please check either "yes" or "no" for each question.

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Abdominal Disease	Yes ☐	No ☐	Gallbladder Trouble	Yes ☐	No ☐	Psoriasis/Eczema	Yes ☐	No ☐
ADD/ADHD	Yes ☐	No ☐	Hay fever/seasonal allergies	Yes ☐	No ☐	Recurrent Headaches	Yes ☐	No ☐
Anemia	Yes ☐	No ☐	Head Injury/ Concussion	Yes ☐	No ☐	Shortness of Breath	Yes ☐	No ☐
Anxiety	Yes ☐	No ☐	Heart Murmur	Yes ☐	No ☐	Sleep Difficulties	Yes ☐	No ☐
Asthma	Yes ☐	No ☐	Heart Palpitations	Yes ☐	No ☐	Sinusitis, chronic	Yes ☐	No ☐
Arthritis	Yes ☐	No ☐	Heart Disease	Yes ☐	No ☐	Stools, abnormal	Yes ☐	No ☐
Bronchitis, chronic	Yes ☐	No ☐	Hernia, groin	Yes ☐	No ☐	Stroke	Yes ☐	No ☐
Cancer	Yes ☐	No ☐	High Blood Pressure	Yes ☐	No ☐	Thyroid Disease	Yes ☐	No ☐
Chronic Cough	Yes ☐	No ☐	Heartburn	Yes ☐	No ☐	Tuberculosis	Yes ☐	No ☐
Chest Pain/Pressure	Yes ☐	No ☐	Hepatitis	Yes ☐	No ☐	Ulcers	Yes ☐	No ☐
Constipation, chronic	Yes ☐	No ☐	Joint Injury	Yes ☐	No ☐	Urine, blood	Yes ☐	No ☐
Convulsions/Seizures	Yes ☐	No ☐	Kidney Disease	Yes ☐	No ☐	Urinary Tract Infections, chronic	Yes ☐	No ☐
Diabetes Insulin or No Insulin?	Yes ☐	No ☐	Liver Disease	Yes ☐	No ☐	Venereal Disease/ STD	Yes ☐	No ☐
Diarrhea, chronic	Yes ☐	No ☐	Lung Disease, COPD	Yes ☐	No ☐	Vision Trouble	Yes ☐	No ☐
Depression	Yes ☐	No ☐	Rashes, recurrent	Yes ☐	No ☐	Weight Loss/Gain	Yes ☐	No ☐
Eating Disorder	Yes ☐	No ☐	Pneumonia	Yes ☐	No ☐	Pain – Lower Back	Yes ☐	No ☐
Pain – Middle Back	Yes ☐	No ☐	Pain – Upper Back	Yes ☐	No ☐	Pain – Shoulder	Yes ☐	No ☐
Pain – Arm	Yes ☐	No ☐	Pain – Hip	Yes ☐	No ☐	Pain – Knee	Yes ☐	No ☐
Pain – Ankle	Yes ☐	No ☐	Pain – Neck	Yes ☐	No ☐	Pain – Other:	Yes ☐	No ☐

Please explain any "yes" answers:

Are you seeing any other doctor for **pain medication**? Yes ☐ No ☐

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MEDICAL HISTORY CONTINUED

Are you a current tobacco user? Yes ☐ No ☐ If **yes**, for how long? _____________ months/years

If **yes**, are you interested in quitting? ________ Yes ☐ No ☐

Do you currently or have you ever: Used illegal drugs? Yes ☐ No ☐ Abused Alcohol? Yes ☐ No ☐ Abused prescription drugs? Yes ☐ No ☐

<u>Please list your current medications:</u>	<u>Please list any drug allergies:</u>
☐ I do **not** take any medications	☐ I do **not** have any known drug allergies

Date of most recent blood work (labs): ______________________

Date of most recent colonoscopy: _______________________ ☐ I have never had a colonoscopy

Have you ever had a glaucoma screening? If yes, please list date. Yes ☐ No ☐ date: ________________

Women: Date of last mammogram screening: ________________________ Date of last PAP: ______________________

Men: Date of last PSA or prostate screening: ______________________

Family History

Do you have a family history (mom, dad, or siblings only) of any of the following?
Please check either "yes" or "no" for each question.

Alcohol Abuse	Yes ☐	No ☐	Arthritis	Yes ☐	No ☐	Alzheimer's	Yes ☐	No ☐
Asthma	Yes ☐	No ☐	Birth Defects	Yes ☐	No ☐	Cancer	Yes ☐	No ☐
COPD/ Lung Disease	Yes ☐	No ☐	Depression	Yes ☐	No ☐	Diabetes	Yes ☐	No ☐
Drug Abuse	Yes ☐	No ☐	Early Death	Yes ☐	No ☐	Hearing Loss	Yes ☐	No ☐
Heart Disease	Yes ☐	No ☐	High Cholesterol	Yes ☐	No ☐	Hypertension	Yes ☐	No ☐
Kidney Disease	Yes ☐	No ☐	Learning Disability	Yes ☐	No ☐	Mental Illness	Yes ☐	No ☐
Heart Attack	Yes ☐	No ☐	Stroke	Yes ☐	No ☐	Vision Loss	Yes ☐	No ☐

Please explain any "yes" answers: ____

____

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CONSENT FOR SPECIFIC USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing below, you consent to Evans Urgent Care's use or disclosure of information about yourself (or for another person for whom you have the authority to sign) that is protected under federal and/or state law.

Information about you is protected under federal and/or state law, and you have the right to revoke this consent, unless we have already taken action based on your authorization. By signing below, you recognize that the protected health information used or disclosed pursuant to the consent may be subject to disclosure by the recipient and may no longer be protected under federal law.

I authorize Evans Urgent Care to communicate with the following individuals regarding my condition or course of treatment:

Name	Relationship
____	_______________________________________
____	_______________________________________

Please initial those items to which you wish to consent:

Evans Urgent Care may call and leave messages on my voice mail/answering machine regarding:

____ Normal lab results ______ Referrals/appointments

☐ **Please check here (and sign below) if you do not wish to list anyone to which your health information may be released to.**

I authorize Evans Urgent Care to communicate confidential information to me, including invoices for services to the following address and telephone numbers:

_____ Please use the address and telephone numbers provided on my patient information sheet.
_____ Please use the following alternate address and telephone numbers:

First Name : _____________________ Initial:___ Last Name:_________________

Street: ____________________ City: ____________ State: ___ ZIP: _____

Home: ( ) ______-_________ Work: ( ) ______-_________ Cell: ( ) ______-_________

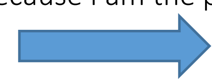
____ Patient's Printed Name

____ Date

____ Signature

____ Printed name if not patient

I am the patient's personal representative and have authority to act for the patient because I am the patient's: ___________________________________.



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Financial Arrangements

Insurance card must be presented at time of service. If you do not have health insurance, payment is due at time of service. If your health insurance policy has a co-payment requirement, payment is due at time of service.

We will file your claim with your health insurance company. If your claim is denied by your insurance company, you will be responsible for the full amount of the bill.

If your policy has deductible or co-insurance requirements, you will be billed for these amounts when your insurance claim is settled. All bills are due upon receipt.

We accept the following methods of payment: Cash, Debit Cards, Major Credit Cards, and subject to approval, Personal Checks. We utilize the Telecheck™ system. It checks your bank history and electronically drafts from your checking account in about three days. If your check is approved, we will return your voided check to you before you leave.

If we accept your check without Telecheck™ approval and it is returned, our Returned Check Fee is $35.00.

Balances over 90 days past due may be charged a Late Fee of $10.00 and may be turned over to a third-party collection agency or attorney for collection.

Subject to appropriate state and federal laws, non-emergency medical services may be denied to patients who have past-due balances.

Please DO NOT discuss financial arrangements with the doctor. If you have any questions, please speak with the office staff or ask for the Practice Manager.

Authorization and Release

I agree to be responsible for payment of all services rendered to me or my dependents under the terms outlined above.

I authorize the release of any information, including diagnosis and the records of any treatment or examination rendered to me or my dependent during the period of such care to third-party payers and/or health-care practitioners.

I authorize and request my insurance company to pay directly to the doctor any benefits otherwise payable to me.

I understand that my insurance company may pay less than the actual bill for services (e.g. required co-payment, co-insurance, deductible or non-covered charges) and that I am responsible for this difference.

I hereby authorize Evans Urgent Care to download my prescription history and to use SureScripts e-prescribe to deliver my prescriptions to my designated pharmacy.
I understand I may request a paper prescription from the doctor.

Signature: ____ Date: ____________________

____________________________________ __________ ___________________________________
Printed First Name MI Last Name

If not the patient, your relationship to patient: ____________________________________

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