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

Patient Information for Workers Compensation/Injuries

Date: ____/____/____

_____ _____ _____ _____
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

Employment: Full Time ○ Part Time ○

____/____/____ _____
Date of Injury Nature of Injury (Area of body & type of injury)

_____

_____

Cause of Injury (What happened)

Is a Drug Screen Required? No _____ Yes _____ Lab -or- Instant
DOT? No _____ Yes ____ (Circle one)

Is a Breath Alcohol Test Required? No _____ Yes _____
DOT? No _____ Yes _____

Workers Compensation/Injuries

_____
Company Name

_____ _____ ____ _____
Street City State ZIP

(_____) _____-_____ (_____) _____-_____
Office Telephone Fax

_____ ____ _____
Supervisor First Name MI Last Name

_____ ____ _____
Authorizing Official First Name MI Last Name

(_____) _____-_____ (_____) _____-_____
Office Telephone

Will a Workers Compensation Insurance Claim be filed? ____ Yes ____ No ____ Unsure

Workers Compensation Insurance

(This information will be **REQUIRED** to file a Workers Compensation insurance claim)

_____ _____
Insurance Company Claim Number

_____ _____ ___ _____
Street City State ZIP

(_____) _____-_____ (_____) _____-_____
Office Telephone Fax

_____
Claim Adjuster or Point of Contact

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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.

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 ☐

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 ☐

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

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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PATIENT CONSENT FORM

Patient Consent for General Use or Disclosure of Healthcare Information

Patient's Name: _____ Date of Birth: _____

SSN: _____ Previous Name (if any): _____

I understand that Evans Urgent Care may use and disclose my personal health information in order to help provide health care to me, to facilitate my billing and payment, and for other health care operations. In general, there will be no other uses or disclosures of this information unless I expressly permit it. I understand that sometimes federal or state law may require release of my health care information without my permission. These situations are very unusual. An example would be if I, the patient, expressed to the doctor a threat to hurt someone.

Evans Urgent Care has a detailed document called the "Notice of Privacy Statement" that contains more information about the policies and practices that protect patient privacy. I understand that I have the right to read the "Notice of Privacy Statement" before signing this agreement.

Evans Urgent Care may update the "Notice of Privacy Statement" and that if I request it, Evans Urgent Care will provide me with the most current "Notice of Privacy Statement."

Under the terms of this consent, I can ask Evans Urgent Care to limit how my personal health information is used or disclosed to carry out treatment, payment or health care operations. I understand that Evans Urgent Care does not have to agree to my request. If Evans Urgent Care does agree to my request, I understand that Evans Urgent Care will follow the agreed limits.

I may cancel this consent in writing at any time by doing ONE of the following:

1: Signing and dating a form that Evans Urgent Care can give me called "Revocation of Consent for Use and Disclosure of Healthcare Information", OR

2: Writing, signing and dating a letter to Evans Urgent Care. This letter will state that I am revoking my consent to use and disclose my personal health information for treatment, payment and healthcare operations.

If I revoke this consent, Evans Urgent Care does not have to provide me with any further healthcare services.

My signature below indicates that I have been given a chance to review the current version of Evans Urgent Care's "Notice of Privacy Act Statement." My signature indicates that I agree to allow Evans Urgent Care to use and disclose my personal health information to carry out treatment, payment and healthcare operations.

_____ _____ _____

Signature of Patient or legally authorized agent Date Time

_____ _____

Printed Name if authorized agent signs Relationship to patient

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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:

_____.