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

Date: ____/____/____

New Patient 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

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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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

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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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: _____.

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: _____

PRIVACY ACT STATEMENT - HEALTH CARE RECORDS

This form is NOT a consent form to release or use Health Care Information pertaining to you.

1. AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING YOUR SOCIAL SECURITY NUMBER (SSN).
Sections 133, 1071-87, 3012, 5031 and 8012, Title 10, United States Code and Executive Order 9397.

2. PRINCIPLE PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED.
This form provides you with the advice required by The Privacy Act of 1974. The personal information you provide will facilitate and document your health care. Your initials and numerical date of birth will be used to identify and retrieve your records.

3. ROUTINE USES.
The Primary use of this information is to provide, plan and coordinate your health care. As prior to enactment of The Privacy Act, other possible uses are: Aid in preventive health and communicable disease control programs and report medical conditions required by law to Federal, State and Local agencies; teach; adjudicate claims and determine benefits; other lawful purposes, including law enforcement and litigation; conduct authorized investigations; evaluate care rendered; determine professional certification and hospital accreditation.

4. DISCLOSURE IS VOLUNTARY AND EFFECT OF INDIVIDUAL OF NOT PROVIDING INFORMATION.
In the case of all beneficiaries, the requested information is voluntary. If the requested information is not furnished, comprehensive health care may not be possible. This all inclusive Privacy Act Statement will apply to all requests for personal information made by health care treatment personnel or for medical/dental treatment purposes and will become a permanent part of your health care record.

Your signature acknowledges only that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.

_____ _____ _____

Patient's Printed Name Date of Birth Today's Date

_____ _____

Signature of Patient/Parent/Guardian 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: _____.