IN A FEW WORDS, PLEASE STATE YOUR SYMPTOMS **NAME:**_____ **Acct#** _____

If Sick, list symptoms below:

_____

If Injured, Location of Injury (Body Part)? _____ **Did you hit your head?** _____ **When?**_____	**How?**_____ **Did this happen at work? ☐YES ☐NO** **Was this a result of a Motor Vehicle Accident? ☐YES ☐NO**

VITALS: OFFICE USE ONLY

*WEIGHT*_____ *B/P*_____ *SPO2*_____ *RESP*_____

*HEIGHT*_____ *TEMP*_____ *PULSE*_____

Self Pay_____

LIFEGUARD URGENT CARE

Patient Registration Form

Acct #_____

Like us on Facebook

Date: _____

Patient Information

SSN:_____

Patient Name (First, Middle, Last):_____

Nick Name: _____ Date of Birth:_____ Sex: F M

Mailing Address:_____ Apt #:_____

City:_____ State:_____ Zip:_____

Home #:_____ Cell #:_____

Email: _____

Marital Status: Child Married Single Separated Widow Divorced (circle one)

Employer Name: _____ Employer #: _____

Primary Care Physician: _____

Phone: _____ Fax: _____

Emergency Contact:_____ Phone:_____

Relationship to Patient:_____

Race:_____ Ethnicity: ___Hispanic ___Non-Hispanic

Preferred Language:_____

PHARMACY

Pharmacy Name: _____ Cross Streets: _____

How did you hear about Lifeguard Urgent Care? (Check one)

__ Friend __Relative __Drive by __Online __ Lifeguard Flyer

__School __Pharmacy __Healthcare Provider __Other_____

NAME:_____

DATE OF BIRTH:_____

Acknowledgement of Notice of Privacy Practices

I have been given the opportunity to read and have had any questions addressed concerning Lifeguard Urgent Care's Notice of Privacy Practices.

You expressly consent and agree that, in order to discuss or service your accounts(s) or to collect amounts you may owe Lifeguard Urgent Care, and its officers, agents, affiliates, employees, and any affiliated or associated service providers and any third-party debt collection agency associated therewith (collectively, We may contact you by telephone at any telephone number associated with the Accounts, including wireless telephone numbers, which could result in charges to you. You expressly consent and agree that We may also contact you by sending text messages, emails, using any e-mail address you provide to us, or by pre-recorded or artificial voice or voice messages, automatic dialing methods, systems, or devices, and pre-recorded or artificial voice prompts at any telephone number associated with the Accounts, including wireless or mobile telephone numbers, regardless of whether you incur charges as a result.

Signature: _____ **Date:** _____

Insurance Authorization and Assignment

I request that the payment of authorized Medicare/insurance benefits be made on my behalf for any services furnished to CMS/insurance carriers and its agents any information needed to determine these benefits or benefits related to services. I hereby authorize Lifeguard Urgent Care garnish information to CMS/insurance carriers concerning my medical condition, illness and treatment to determine the benefits for related services. I hereby authorize (assign) my insurance carrier/CMS to make payment directly to Lifeguard Urgent Care for medical/diagnostic or surgical benefits payable for the services rendered. I understand that any unpaid balance not covered by this policy will be paid by me. I understand and agree (regardless of my insurance status), that I am ultimately responsible for the balance of any professional services rendered. I understand that I am responsible for any charges incurred if my account is sent to a collection agency and for any returned checks. I understand that CMS and/or other insurance carriers do no cover all office services/procedures. I agree to take full responsibility for any unpaid balances and that such payment will be made to Lifeguard Urgent Care for services rendered. I certify that the information I have given here is true and correct to the best of my knowledge. I will also notify you (the office) of any changes in the above information.

Out of Network Plans: I acknowledge that it is my responsibility to verify whether Lifeguard Urgent Care is in-network with my insurance plan. I agree to pay any balance which results from out-of-network charges. I understand that if the facility is not participating in my insurance, I will be responsible for any additional out of pocket costs. I also understand that in some instances, my insurance may not cover any or all benefits and I will not hold Lifeguard Urgent Care liable for any obscure or omitted contractual language in my insurance contract.

Signature: _____ **Date:** _____

Consent for Medical Treatment

FOR ADULTS

I, the patient or authorized patient representative, consent to any medical examination, evaluation and treatment regarding any illness, injury, and/or health concern affecting me at any time I present to Lifeguard Urgent Care for medical treatment. These services may include, but are not limited to laboratory procedures, x-ray examinations, and medical and/or surgical treatment procedures.

Signature of Patient/Patient Representative:_____ **Date:**_____

FOR MINOR PATIENTS

Name of Custodial/Legal Guardian:_____
Relationship to Minor:_____
Custodial/Legal Guardian Signature:_____ **Date:**_____

HIPAA Privacy Notice

I have reviewed a copy of Lifeguard Urgent Care's Privacy Notice and acknowledge this by signing below (a copy will be furnished upon request).

Signature: _____ **Date:**_____

NAME:_____

DATE OF BIRTH:_____

Medical History

The following questions pertain to the **Patient's Parents:**

	Father			Mother			
	Yes	No	Unk		Yes	No	Unk
Cardiovascular Disease	☐	☐	☐	Cardiovascular Disease	☐	☐	☐
High Cholesterol	☐	☐	☐	High Cholesterol	☐	☐	☐
Cancer	☐	☐	☐	Cancer	☐	☐	☐
High Blood Pressure	☐	☐	☐	High Blood Pressure	☐	☐	☐
Lung Disease	☐	☐	☐	Lung Disease	☐	☐	☐
Brain Aneurysm	☐	☐	☐	Brain Aneurysm	☐	☐	☐
Diabetes	☐	☐	☐	Diabetes	☐	☐	☐
Alzheimer's	☐	☐	☐	Alzheimer's	☐	☐	☐
Psychiatric	☐	☐	☐	Psychiatric	☐	☐	☐

Medications

Name	Dose	Frequency

Allergies

Name	Type (food/drug)	Reaction

WOMEN ONLY

Are you pregnant?_____ If yes, what is your due date?_____

Date of Last Period _____

NAME:_____

DATE OF BIRTH:_____

Patient Medical History

PLEASE CHECK ALL THAT APPLY

SURGICAL HISTORY

☐ I have no surgical history

or

☐ Adenoids (w/o tonsils)
☐ Tonsils (w/o adenoids)
☐ Adenoids & Tonsillectomy
☐ Appendectomy
☐ Back – Reason _____
☐ Cancer (Type): _____
☐ Cataract(s)
☐ C-Section: # of times_____
☐ Gallbladder
☐ Ear Tubes: # of times_____
☐ Heart Bypass
☐ Heart Stents
☐ Hysterectomy
☐ Mastectomy
☐ Pacemaker
☐ Tubal Ligation
☐ Vasectomy

☐ Other _____
_____
_____
_____
_____
_____

MEDICAL HISTORY

☐ I have no medical history

or

☐ A. Fib	☐ Gout
☐ Acid Reflux	☐ Heart Attack
☐ ADD/ADHD	☐ Heart Disease
☐ Anxiety	☐ Hepatitis
☐ Arthritis/DJD	☐ High Blood Pressure
☐ Asthma	☐ High Cholesterol
☐ CHF	☐ Hypothyroid
☐ COPD/Emphysema	☐ Kidney Disease
☐ Crohn's	☐ Kidney Stone
☐ CVA/Stroke	☐ Migraines
☐ Dementia	☐ Neuropathy
☐ Depression	☐ Parkinson's
☐ Diabetes	☐ Pulmonary Embolism
☐ Diverticulitis	☐ Rheumatoid Arthritis
☐ Endometriosis	☐ Sciatica
☐ Fibromyalgia	☐ Sleep Apnea
☐ Gallstones	☐ TIA
☐ Glaucoma	☐ Other (Describe Belo

☐ Other_____
_____
_____
_____
_____

SOCIAL HISTORY

	Yes	No		Yes	No
Tobacco Use	☐	☐	Alcohol	☐	☐
Street/Unprescribed Drugs	☐	☐	Recent Travel	☐	☐

NAME:_____

DATE OF BIRTH:_____