Urgent Care of Morgan City

1216 Victor II Blvd. Suite 400
985-412-2020

Please present your insurance card and photo ID at time of check-in.

Please select one:

☐ Insurance ☐ Self-pay (payment due at time of service)

☐ On-the-job injury (Workers' Comp) ☐ Other: _____

Please <u>stop now and notify the receptionist immediately</u> if you are experiencing any of the following:

SEVERE chest pains **SEVERE shortness of breath**
Uncontrolled bleeding **SEVERE Allergic reaction**
Any other life-threatening condition

Patient Information:

Please complete with Patient's Full Legal Name.

Last Name: _____First Name: _____ MI: _____

Birthdate: _____ SSN: _____ Gender: ___M ___F Race: _____

Street Address: _____City: _____ ST: _____Zip: _____

Mailing Address: _____ City: _____ ST: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Preferred Phone Number: _____ May we leave a message regarding your care? ___Y ___N

Email (optional): _____ Marital Status: _____

Occupation: _____ Work Phone: _____

Employer and Address: _____

Emergency Contact: _____ Phone: _____

Emergency Contact Relationship to Patient: _____

Reason for today's visit: _____

Policyholder Information:

*Please complete this section if the patient is **NOT** insurance policy holder, or is under 18 years of age!*

Guarantor Name: _____ Relationship: _____

Street Address: _____ City: _____ St: _____ Zip: _____

Birthdate: _____ SSN: _____ Phone Number:_____

Employer:_____ Gender: ___M ___F

How did you hear about us? ☐Dr. Referral ☐ Existing Patient ☐Friend ☐ Internet ☐ Relative ☐Signage ☐Newspaper ☐ Facebook ☐ Other _____

Is this an on-the-job or other work-related injury? ☐Y ☐ N

If yes, please complete the following:

Employer Name: _____ Address: _____

Supervisor Name: _____ Supervisor Phone Number: _____

Date of Injury: _____

Description of Injury/Symptoms: _____

Authorization and Release For ALL Treatment at this Facility:

Authorization For Treatment: I voluntarily consent to the administration and cost of medical and surgical procedures, x-ray, and medication for myself and my dependents.

Assignment of Insurance Benefits: I authorize payment directly to Urgent Care of Morgan City for all benefits and the release of medical information for all services and payments otherwise payable to me.

Guarantee of Payment: I understand that I am financially responsible and agree to pay all of the charges that are not paid or billed to insurance or any other third party payer. I understand that I must pay in full today for all services rendered unless my insurance is accepted. I also understand that if my insurance is accepted, I must pay all applicable insurance copays, coinsurances, and deductibles today. If Urgent Care of Morgan City is unable to verify my insurance at time of service, I will pay in full for all services.

Release of Records: I authorize Urgent Care of Morgan City to release (verbal or in writing) confidential medical information to any person or entity including my insurance carrier, employer if treatment is related to employment purposes, or other health care operations, which may be liable to me or my practitioner(s) for charges for this treatment and for quality management, utilization review, transfer, and follow-up purposes.

Receipt of HIPPA Forms: I acknowledge that I have read the Urgent Care of Morgan City HIPPA Compliance forms.

I understand that a copy of this agreement may be used with the same effectiveness as the original.

PATIENT SIGNATURE _____ **DATE** _____

RESPONSIBLE PARTY _____ **DATE**_____

Patient Health History

- ☐ Abnormal heart rhythm
- ☐ Alcoholism
- ☐ Anxiety
- ☐ Arthritis
- ☐ Cholesterol disorder
- ☐ Coronary artery disease
- ☐ Depression
- ☐ Diabetes
- ☐ Drug dependency
- ☐ Fainting / dizzy spells
- ☐ Gallbladder disease
- ☐ Glaucoma
- ☐ Gastrointestinal disorders
- ☐ Hearing disorder
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Kidney disease
- ☐ Lung disease
- ☐ Migraine headaches
- ☐ Seizure disorder
- ☐ Sleep disorder
- ☐ Stroke
- ☐ Thyroid disorder
- ☐ Weight problems
- ☐ Other:
- ☐ Other:

Do you Smoke? ☐ YES ☐ NO
How Much? _____
Alcohol use? ☐ YES ☐ NO
How Much? _____

WOMEN ONLY
- ☐ Pregnant
- ☐ Breast Feeding
- ☐ Hysterectomy
- ☐ Birth Control

Type: _____
Date of last menstrual period: _____

If you placed a mark on anything above please specify below.
(I.e. Lung disease Asthma)

_____
_____

Current Medications:

_____
_____

Allergies to medications? _____
Reaction:_____

Primary Doctor: _____ **Phone #:** _____
Address:_____
City_____ **State** ____**Zip**_____

Preferred Pharmacy: _____ **Phone #:** _____
Address:_____
City_____ **State** ____**Zip**_____

Family Health History

- ☐ Abnormal heart rhythm
- ☐ Alcoholism
- ☐ Anxiety
- ☐ Arthritis
- ☐ Cholesterol disorder
- ☐ Coronary artery disease
- ☐ Depression
- ☐ Diabetes
- ☐ Drug dependency
- ☐ Fainting / dizzy spells
- ☐ Gallbladder disease
- ☐ Glaucoma
- ☐ Gastrointestinal disorders
- ☐ Hearing disorder
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Kidney disease
- ☐ Lung disease
- ☐ Migraine headaches
- ☐ Seizure disorder
- ☐ Sleep disorder
- ☐ Stroke
- ☐ Thyroid disorder
- ☐ Weight problems
- ☐ Other:
- ☐ Other:

Notes:

_____
_____
_____
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