Swift Health Urgent Care

Date:

PATIENT	REGISTRATION
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			PRINT	AND COM		NTR	IES			
PATIENT NAME (LAST FIRST MIDDLE INITIAL)				ADDRESS						
					1					
CITY, STATE			Z	ZIP	HOME PHON	NE		С	ELL PHONE	
PATIENT DATE OF BIRTH	PATIENT SSN	N					MARITAL S			
				Male Female Single			Single 🛛	Married 🛛 Other		
PATIENT EMPLOYER NAM	E	PATIENT EMP	PLOYE	R ADDRESS (S	STREET ADDR	ESS -	CITY - STAT	E - ZIP) EMPLOYER PHONE		
INSURED/RESPO	NSIBLE PARTY 1	INFORMATION	N	RELATI	ON TO PATI	IENT	: 🗆 spous	e 🗆 pa	arent 🛛 guardian	
NAME (FIRST LAST M	IDDLE INITIAL)		ADD	RESS (if diffe	erent from pat	tient)	·			
HOME PHONE	WORK PHON	E	SSN		B	IRTH	DATE	EMPLOYER		
			INSU	JRANCE INFO	ORMATION					
PRIMARY INSURANCE NA	ME	ADDRE	SS (ST	REET - CITY - STATE - ZIP)			PHONE			
GROUP NUMBER	ID NUMBER		EMPL	EMPLOYER			EMPLO	EMPLOYER PHONE		
SECONDARY INSURANCE NAME ADDRESS (ST				STREET - CITY - STATE - ZIP)			PHONE			
					_	,				
GROUP NUMBER	ID NUMBER EMI			IPLOYER			EMPLOYER PHONE			
PRIMARY DOCTOR/FAMILY DOCTOR				REFFERING DOCTOR						
IN CASE OF EMERGENCY CONTACT				RELATIONSHIP				PHONE NUMBER		
I										

ASSIGNMENT AND RELEASE : I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.
SIGNATURE (Patient or, if minor Signature of parent or guardian)
DATE
DATE

Authorization to release health information to:				
Name(s)	ADDRES	5		
CITY, STATE	ZIP	HOME PHONE	DAYTIME PHONE	
DATES OF SERVICE	AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN IN EFFECT ONE YEAR FROM THE DATE SIGNED)			
FROM: TO:		ATE:		
Release the following information:				
All Records Chart Notes	Radiology Re	oorts Operative Reports	History & Physicals	

RELEASE OF INFORMATION

I understand that:

•	"this facility" discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a third
	party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my
	health information.

• I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524).

• my records are protected and cannot be disclosed without written permission

• this Authorization will remain in effect for one year or I provide a written notice of revocation to the Practice Manager

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE	EMAIL
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	SIGNATURE OF WITNESS (Optional)):

Swift Health Urgent Care

Date: _____

PATIENT MEDICAL HISTORY

#**Reson for your vidit: (rew) (Recurrent) (chonic) how you had this problem? What Harges Outprovides Daily Focusion Daily Focusion Daily Focusion Daily Focusion Daily Focusion State Drugs Wheat Ansthesia Problems Anthrus Anthrus Anthrus State Drugs Wheat MOTHER FATLY HISTORY - Please Indicate if any of your immediate relatives have had any of the following by plecing an X in the appropriate box. Anesthesia Problems Anthrus Cancer Diabetes Heart Problems Martial status: Stroke Thypoid Disorder Social, HISTORY Martial status: Singlical History: Please list any hospitalizations, surgeries, fractures or major Illnesses you have had. TYPE OF SURGERY VEAR or DATE Medical History: Have you eyer had any of the following? Notic for the problems listed Chest pain artifition Chest pain and fitis problems Incertapin	PATIENT NAME (LAST FIRST MIDDLE INITIAL) and Date of Birth							
Notified in the set of t	(new) (Recurrent) (chronic) How long have you had this problem?							
THER: FAMILY HISTORY - Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box. Anesthesia Problems FATHER SIBLING (torother/Sister) Arthritis Image: Signal Si	 NONE/No Known Allergies Dairy Products 	Iodine/Shellfish/Contrast Dye			-			
FAMILY HISTORY - Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box. MOTHER FATHER SIBLING (Brother/Sister) Anesthesia Problems	2							
MOTHER FATHER SIBLING (Brother/Sister) Archthritis								
Anesthesia Problems	FAMILY HISTORY - Ple			have had a				
Arthritis	Anesthesia Problems				FAIRER		LDLING (Brother/Sister)	
Cancer								
Diabetes								
Heart Problems								
Hypertension								
Stroke								
Thyroid Disorder								
SOCIAL HISTORY								
Marital status: Single Married Divorced Widowed Separated Occupation:								
Occupation:		e 🗆 Married 🗆 Divorced 🗆	Widowed □ Se	parated				
Yes No - Do you drink alcohol?	-				ed (reason)	
Yes No - Do you use tobacco? Smoke (packs per day) Chew Surgical History: Please list any hospitalizations, surgeries, fractures or major illnesses you have had. IOCATION TYPE OF SURGERY YEAR or DATE DOCTOR LOCATION Medical History: Please list any hospitalizations, surgeries, fractures or major illnesses you have had. IOCATION IOCATION Medical History: Have you ever had any of the following? Intervention Intervention organ injury Noke of the problems listed Cheft congestive heart failure hyperlipidemia organ injury altergies Chronic fatigue syndrome hypogonadism male putnonary embolism/blood clot in legi artinitis conditions depression hypogonadism male putnonary embolism/blood clot in legi astima diabetes infording problems sistus conditions astima diabetes infording problems sistus conditions BPH fibromyalgia kidney problems syndrome X Carcler heart disease migraines/headaches wheat allergy cardica carrest high cholesterol neuropathy organ hyperinsulinemia onychomycosis Medications: List any me		rink alcohol?				olic	/	
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CAD coronary artery disease Gerd menopause tremors cancer heart disease migraines/headaches wheat allergy cardiac arrest high cholesterol neuropathy wheat allergy celiac disease hyperinsulinemia onychomycosis wheat allergy Medications: List any medications you are currently taking (please include over the counter medications): PERSCRIBING DOCTOR PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE DOSAGE PERSCRIBING DOCTOR Vitals: Vitals: Vitals Vitals	bleeding problems	erectile dysfunction	n	irritable	bowel syndrome	stroke		
cancer heart disease migraines/headaches wheat allergy cardiac arrest high cholesterol neuropathy celiac disease hyperinsulinemia onychomycosis Medications: List any medications you are currently taking (please include over the counter medications): PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE MEDICATION DOSAGE Vitals:	ВРН	🗖 fibromyalgia		🔲 kidney p	problems	Syndrome X		
cardiac arrest high cholesterol celiac disease hyperinsulinemia Medications: List any medications you are currently taking (please include over the counter medications): PLEASE PRINT LEGIBLY - NO CURSIVE PLEASE MEDICATION DOSAGE PERSCRIBING DOCTOR Vitals:	CAD coronary artery diseas					tremors		
celiac disease hyperinsulinemia onychomycosis Medications: List any medications you are currently taking (please include over the counter medications): PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE MEDICATION DOSAGE PERSCRIBING DOCTOR						wheat allergy		
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