URGENT CARE
OF MISSOURI

Where did you hear about us?_____

PATIENT DEMOGRAPHIC

Last Name:_____ First Name:_____

Date of Birth:____/____/_____ SSN:_____-_____-_____Race/ Ethnicity:_____ M / F

Phone:_____Mailing Address:_____APT#_____

City:_____ State:_____ Zip:_____ EMAIL:_____

PARENT/ GUARDIAN INFORMATION (if patient is under 18)

Name:_____ DOB:_____ SSN:_____ Relationship:_____

EMERGENCY CONTACT INFORMATION

Name:_____ Phone:_____ Relationship:_____

_____I understand that I am responsible for all copays and coinsurance payments at the time of service and will be responsible for services that are not covered by insurance. Self pay patients, you will be responsible for the full amount of the visit at the time of service.

_____I authorize my healthcare provider and other providers who may attend me, their assistants, including those employed by Urgent Care of Missouri, its in house staff and students to provide medical care, test, procedures, drugs, services and supplies considered advisable by my healthcare providor.

_____I authorized Urgent Care of Missouri to contact me via text or email for survey purposes.

MEDICAL HISTORY

Pharmacy Name_____

Are you currently taking any medications? _____YES _____NO

MEDICATION	STRENGTH	TIMES PER DAY	***Are you allergic to any medications***?
			_____ YES _____NO

Please list all past surgeries

_____ NONE

_____

_____

_____

_____

_____

Please list all medical conditions, or chronic medical problems that you have

_____NONE

_____

_____

_____

_____

HIPAA PLEASE READ

I authorize Urgent Care of Missouri to disclose all protected health information described in the HIPPA information paper to (list anyone that we could talk to about your visit):

_____

List any and all medical information that you would like withheld from any person listed above:

_____

Effective period: please select one of the following options

_____ all past, present and fututre visits

_____ from ___/___/___ to ___/___/___

I understand that I can change any/ all of the information at any time

I understand that I have the right to all of my medical records

I have read over the HIPPA information available to me at this office

Signature:_____ Date:____/____/____

Printed name:_____

Relationship to patient if patient is under 18:_____