BENCHMARK URGENT & FAMILY CARE

REGISTRATION PACKET

Welcome to Benchmark Urgent & Family Care. If you are new to Benchmark Urgent & Family Care or have had a change in your demographic or medical information, please complete the enclosed registration packet and bring it with you to your visit. Along with the packet please bring your insurance card(s), valid photo ID and method of payment.

If you are experiencing any of the following medical conditions, please seek immediate medical attention at your nearest emergency facility or dial 911.

1. Chest pain (not associated with coughing or flu symptoms), pressure or heaviness in the chest, chest pain that radiates into the shoulder, arm, back or jaw, heart attack

2. Difficulty breathing, shortness of breath, asthma attack

3. Severe or uncontrolled bleeding

4. Loss of consciousness, fainting or seizure

5. Foreign object in the eye or chemicals splashed in the eye

6. Medication overdose or ingestion of a chemical

7. Sudden onset of one-sided extremity or facial weakness, difficulty speaking, blurred vision, dizziness, headache, confusion, disorientation or other symptoms of a stroke

8. Possible contagious rash (such as chickenpox, scabies, measles)

9. Fall or motor vehicle crash with neck pain, numbness, weakness or tingling in the extremities

10. Severe abdominal pain

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PATIENT REGISTRATION

First Name: ______________________ MI: ________ Last Name: ______________________

Gender: ❑ Female ❑ Male Date of Birth: ____________ Primary Language: ❑ English ❑ Spanish ❑ Other: ____________

Race: ❑ White ❑ Black/African American ❑ Asian ❑ Asian Indian ❑ American Indian ❑ European ❑ Filipino ❑ Japanese ❑ Korean ❑ Native Hawaiian/Pacific Islander ❑ Refused

Ethnicity: ❑ Not Hispanic or Latino ❑ Central American ❑ Cuban ❑ Dominican ❑ Hispanic, Latino/Spanish ❑ Latin American/Latin, Latino ❑ Mexican ❑ Puerto Rican ❑ South American ❑ Spaniard ❑ Refused

How Did You Hear About Us: ❑ Family/Friend ❑ Primary Care ❑ Insurance Co. ❑ Other Physician/Medical Office ❑ Emergency Room ❑ Ambulance/EMT ❑ Pharmacy ❑ School/Day Care ❑ Employer ❑ Hotel ❑ Other Business/Organization ❑ Newspaper/TV/Radio ❑ Drive-by/Center Signage ❑ Internet Search/Ad ❑ Direct Mail/Ad to Home ❑ Community Event ❑ Other ____________

CONTACT INFO

Home Phone No.: ____________ ❑ My Cell Phone is My Only Phone Mobile/Cell Phone No.: ____________

Check, if we have permission to, ❑ leave messages ❑ send texts to your cell phone. Email Address: ____________

ADDRESS

Residence: ______________________ Apt No.: ____________

City: ______________________ State: ____________ Zip: ____________

Mailing: ❑ Same as Residence If different: ______________________ Apt No.: ____________

City: ______________________ State: ____________ Zip: ____________

Listed w/ Insurance Co.: ❑ Residence ❑ Mailing ❑ Other: ____________

MARITAL STATUS (Adults Only)

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

If married, Spouse's Full Name: ______________________ Phone No.: ____________

PARENT-GUARDIAN (Minor or Incapacitated Adults Only)

First Name: ______________________ Last Name: ______________________

Phone No.: ____________ Email: ____________ Relationship to Patient: ____________

Address (if different): ______________________

EMERGENCY CONTACT

❑ Spouse is Emergency Contact ❑ Parent/Guardian Emergency Contact

Name: ______________________ Phone No.: ____________ Relationship to Patient: ____________

PHARMACY

Would you like your prescriptions electronically transferred to a pharmacy? □ Yes □ No Pharmacy Name: ____________

Address: ______________________ Phone No.: ____________ Fax No: ____________

INSURANCE

❑ No Insurance ❑ Patient Holds Insurance ❑ Other Person Holds Insurance Patient's Social Security No.: ____________

If someone other than patient holds the insurance, complete below:

Holder's Name: ______________________ Holder's Date of Birth: ____________

Holder's Mailing Address: ______________________ Holder's Phone No: ____________

Holder's Relationship to Patient: ____________ Holder's Employer: ____________ Holder's Social Security No.: ____________

EMPLOYER

Name: ______________________ Occupation: ____________

Is today's visit related to work place injury? ❑ Yes ❑ No **If yes, complete below:**

Supervisor: ______________________ Phone No. ____________ Date of Injury: ____________

Address: ______________________

Carrier's Name: ____________ Carrier's Address: ______________________

Policy No: ______________________ Claim No.: ______________________

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MEDICAL, FAMILY, SOCIAL HISTORY

Medication-Drug Allergies: ______________________________

____

Food & Environmental Allergies: ______________________________

____

Current Medications (prescription, over-the-counter, supplements, vitamins): ______________________________

____

____

Primary Care Provider

Name: ______________________ Practice Name: ______________________

Phone No.: ______________________

Past Medical History

Have you been diagnosed with any of the following?

- ❑ Abnormal Heart Rhythm
- ❑ Anxiety
- ❑ Arteriosclerosis
- ❑ Arthritis
- ❑ Asthma
- ❑ Blood Clots
- ❑ Cancer
- ❑ Cholesterol - Triglyceride Disorder
- ❑ COPD - Pulmonary Disease
- ❑ Congestive Heart Failure (CHF)
- ❑ Depression
- ❑ Diabetes
- ❑ Gallbladder Disease
- ❑ Glaucoma
- ❑ Headaches
- ❑ Hiatal Hernia
- ❑ Hypertension - High Blood Pressure
- ❑ Kidney Disease - Uremia
- ❑ Kidney Stones
- ❑ Hypotension - Low Blood Pressure
- ❑ Lung Disease
- ❑ Muscle Disease
- ❑ Pulmonary Hypertension
- ❑ Renal Disease
- ❑ Seizure Disorder
- ❑ Sleep Disorders
- ❑ Stomach - GI Disorders
- ❑ Stroke
- ❑ Thyroid Disorders
- ❑ Tremor
- ❑ Ulcer Disease
- ❑ Urinary Infections

Children, Ages 10 and under

- ❑ Premature - Complications at Birth
- ❑ Ear Infections
- ❑ Febrile Seizure

Vision and Hearing

- ❑ Hearing Problems
- ❑ Wear Hearing Aid
- ❑ Wear Contact - Glasses
- ❑ Wear Glasses for Reading Only

Surgeries – Procedures

- ❑ Appendix Removal
- ❑ Blood Transfusions
- ❑ CABG (Heart Surgery)
- ❑ Gallbladder Removal
- ❑ Hernia Repair
- ❑ Hysterectomy (circle: Total-Partial)
- ❑ Pacemaker
- ❑ Tonsils Removal
- ❑ Tubal Ligation
- ❑ TURP
- ❑ Stomach Surgery
- ❑ Thyroid Surgery
- ❑ Spleen Surgery

Other Medical History: ______________________________

____

Female Only

Last Menstrual Period: ____________ Birth Control ❑ Yes ❑ No Type: ______________________

Family History

Biological Parents: Mother: ❑ Alive ❑ Deceased at age ________ from: ______________________

Father: ❑ Alive ❑ Deceased at age ________ from: ______________________

Other Family History: ______________________________

Social History

Tobacco Use: ❑ No ❑ Yes Type: ❑ Cigarettes/Cigars ❑ Chewing Tobacco Daily Amount: ______________

Alcohol Use: ❑ Never ❑ Rarely ❑ Occasional ❑ Heavy

Illicit Drug Use: ❑ Never ❑ Rarely ❑ Occasional ❑ Heavy Type: ______________________

Recently Traveled Abroad: ❑ No ❑ Yes, Loc. ______________________ Dates: ______________

Contact with International Travelers/Visitors: ❑ No ❑ Yes

Children: ❑ Attends Daycare or Care Outside the Home ❑ Attends School ❑ Care or Schooling in Home

SIGNATURE

Date Completed: ____________ **Completed by:** ❑ **Patient** ❑ **Parent/Guardian/Other** **Signature:** ______________________

BENCHMARK URGENT & FAMILY CARE

Privacy and Billing Procedures Authorization and Acknowledgement

These authorizations/acknowledgements cover all services rendered to me, or the patient I am signing for, today and all future dates of service. I understand I may revoke this authorization by informing Benchmark Urgent & Family Care in writing but if I do revoke this authorization, it will not affect anything prior to the date the revocation is received by Benchmark Urgent & Family Care.

Acknowledgement of Receipt of Notice of Privacy Practices
Authorization to Release Information to Family/Friends or Others

I have received a copy of Benchmark Urgent & Family Care's Notice of Privacy Practices. I authorize Benchmark Urgent & Family Care to release any information regarding my treatment including lab results, x-rays and medical records, to the following individuals (Benchmark Urgent & Family Care may not release information or records to the named individuals unless you identify them here):

Name: ____________________ **Relationship to Patient:** ____________________

Name: ____________________ **Relationship to Patient:** ____________________

Benchmark Urgent & Family Care will use my preferred phone number and my primary address supplied during registration to contact me, including leaving messages, regarding my treatment including lab results, x-rays and medical records. I will ensure this information is up-to-date at every visit.

Authorization to Treat and Bill

I consent to be treated by Benchmark Urgent & Family Care. If I am not the patient being treated today I am authorized to consent to treatment and billing for the patient identified below. I authorize Benchmark Urgent & Family Care to bill my medical insurance for the care I receive today and to release any information the insurance carrier requires to process this bill. I authorize payment of medical benefits to Benchmark Urgent & Family Care, or to outside labs as described below, for all services performed and billed by Benchmark Urgent & Family Care. I understand that I am responsible for all charges for the treatment I receive at Benchmark Urgent & Family Care today.

As a courtesy, Benchmark Urgent & Family Care will bill my medical insurance. If I do not provide complete and accurate insurance information to Benchmark Urgent & Family Care, I understand Benchmark Urgent & Family Care may not receive payment from my carrier and I will be entirely responsible for my bill. Even after my medical insurance company pays Benchmark Urgent & Family Care's bill, I may owe Benchmark Urgent & Family Care payment for services not covered by my insurance and I agree to pay these promptly to Benchmark Urgent & Family Care. I understand that Benchmark Urgent & Family Care may send lab specimens to an outside laboratory. I authorize any lab performing services for me to bill my medical insurance for their services. I understand that my medical insurance may not pay for all services provided by the lab and I agree to pay any remaining balance promptly to any outside lab providing services to me. I understand that Benchmark Urgent & Family Care is not responsible for payment to outside labs for tests provided to me.

To protect my privacy and prevent fraud, I understand that if I cannot provide acceptable photo identification at the time of service that Benchmark Urgent & Family Care may choose not to bill insurance and may decline credit/debit cards and checks as a form of payment. I understand that if I fail to pay Benchmark Urgent & Family Care for services provided to me, the balance owed may be sent to collections and I may incur collection costs of up to 25% in addition to the amount owed for treatment. I understand that I may contact Benchmark Urgent & Family Care to work out payment arrangements that may prevent this additional cost.

Signature: ____________________ **Date:** ____________________

Patient Name: ____________________ **Patient DOB:** ____________________

____________________ ____________________

Name of Patient Representative Signing for Patient **Relationship of Patient Representative to Patient**

(required if the patient is a minor or an adult who is unable to sign this form)