Wellness

Walk-In Clinic

Patient Information Sheet

Patient Name: Last _____ First _____ MI_____

SSN: _____ **Sex**: M F **Date of Birth**: _____

Address: Street_____

City_____ State_____ Zip_____

Phone: Home_____ Cell: _____ E-mail: _____

Employer: _____ **Employer Phone**: _____

Marital Status: (circle one) Single Married Divorced Widowed Life Partner Other

Race: American Indian Asian African American Caucasian Hispanic/Latino Pacific Islander

Emergency Contact: _____ Phone: _____ Relationship:_____

Pharmacy: _____ **Location**: _____

Insurance Information- Disregard if card is presented

**Primary Insurance: _____ ID: _____

Insured's Name (if different than patient) _____

Relationship to patient: Self Spouse Child Other _____

Insured's DOB: _____ SS#: _____

Address of Insured if different than patient: _____

**Secondary Insurance: _____

Insured's Name (if different than patient) _____ _____

Relationship to patient: Self Spouse Child Other _____

Insured's DOB: _____ SS#: _____

Address of Insured if different than patient: _____

Permission/Assignment Release

I hereby authorize you to provide necessary medical treatment. I authorize that my insurance benefits be paid direct to: Wellness Walk-In Clinic, LLC. I accept financial responsibility for all unpaid services and authorize Wellness Walk-In Clinic, LLC to release information as required for patient care and billing purposes. If I should fail to pay my balance, I agree to pay all cost of collection including attorney, collection fees, and contingent fees to collection agencies of not less than 35%, such contingency fee to be added and collected by the collection agency immediately upon your default and Wellness Walk-In Clinic, LLC referral of your account to said collection agency. I agree that this authorization shall be valid until rescinded in writing when the information is released in reliance upon this consent. A photocopy of this assignment shall be considered as valid as the original. I have read and fully understand the terms thereof. Credit balance of under $20.00 will remain on your account and applied to future visits or we can apply amount to a credit card.

Patient/Guardian Signature: _____ Relationship: _____ Date: _____

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Social History:

Alcohol: Social Occasional Light Heavy Never
Tobacco: Cigarette Cigars E-Cigarettes Pipe Chew or Dip Former Smoker Never Smoked
Illicit Drug Use: NO YES If yes, please specify: _____

Medical History: Circle all that apply

ADD	Depression	High Cholesterol
ADHD	Diabetes	HIV
Anemia	Diverticulitis	Kidney Stones
Anxiety	Eczema	Lung Problems
Arthritis	GERD	Migraines
Asthma	Glaucoma	Prostate Problems
Autoimmune Disorder	Gout	Seizures
Bipolar	Heart Problems	STDs
Cancer	Hepatitis	Stroke
Cataracts	High Blood Pressure	Ulcerative Colitis

Other:

_____

Current Medications: Please list all medication names, doses, and directions or if none circle **N/A**

_____

_____

Allergies: Please list below or if none circle **N/A**

_____

_____

Surgeries: Please list all surgeries and their approximate dates or if none circle **N/A**

_____

_____

Hospitalizations: Please list hospital stays other than surgeries

_____

Family History: Circle all that apply or **N/A** if there is no family history to report

Mother: Cancer CAD CHF High Cholesterol Stroke Diabetes Hypertension MI

Father: Cancer CAD CHF High Cholesterol Stroke Diabetes Hypertension MI

Wellness Walk-In Clinic, LLC

2612 Hough Road

Florence, AL 35630

Patient Authorization Information

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties described below. I understand that if any party that calls to obtain information about me that is not listed on this form, the information will not be released to the specific party unless it is your insurance company needing medical information.

The following person(s) _____ are authorized to make request for the following information: Please circle:

Clinic Notes History & Physical Medications X-ray Reports

EKG Immunizations Pathology Reports Laboratory Reports

Other_____ ALL OF THE ABOVE

I understand that I may inspect or copy the protected health information to be used or disclosed. I may revoke this authorization in writing by contacting Wellness Walk-In Clinic, LLC attention Privacy Officer. Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA. I may refuse to sign this authorization and that you, Wellness Walk-In Clinic, LLC will not condition treatment or payment on me providing this authorization.

Signature: _____ Date: _____

This authorization shall remain in effect from the date signed until: _____

Acknowledgement of Receipt of Notice of Privacy Practices

Notice to Patient:
We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice. You may refuse to sign this acknowledgement if you wish.

I acknowledge that I have receive a copy of this office's Notice of Privacy Practices.

Patient/Guardian Signature: _____ Date: _____
Relationship: _____