

UCE: Patient Registration

Account #: _____

Patient Information

Last Name:

First Name:

Initial:

Local Address:

City:

State:

Zip:

Permanent Address:

City:

State:

Zip:

Date of Birth:

Social Security Number:

Sex: Male FemaleMarital: Divorced Married Single Widowed

Home #:

Cell #:

Work #:

Other #:

Email:

Employer:

Minors Only

Mother's Full Name:

Mother's Employer:

Father's Full Name:

Father's Employer:

Married Only

Spouse's Full Name:

Spouse's Employer:

Primary Insurance Information

 No Insurance Patient Holds Insurance Other Person Holds Insurance

Guarantor's Full Name:

Social Security Number:

Date of Birth:

Sex: Male FemaleRelationship to Patient: Myself Spouse Child Other _____

Insurance Company:

Policy Number:

Group Number:

Co Pay Amount:

Type: PPO POS HMO Medicare Medicare Managed Care AHCCCS

Secondary Insurance Information

 No Insurance Patient Holds Insurance Other Person Holds Insurance

Guarantor's Full Name:

Social Security Number:

Date of Birth:

Sex: Male FemaleRelationship to Patient: Myself Spouse Child Other _____

Insurance Company:

Policy Number:

Group Number:

Co Pay Amount:

Type: PPO POS HMO Medicare Medicare Managed Care AHCCCS

Signature

Patient/
Guarantor:

Date:

How did you hear or find out about Urgent Care Express?

UCE: Privacy Procedures Authorization & Acknowledgement

These authorizations, acknowledgements and waivers cover all services rendered to the below patient for today's services and all future dates of service. You may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any events that occurred before you notified us of your decision to revoke.

Acknowledgement of Receipt of Notice of Privacy Practices

I have the Notice of Privacy Practices for the patient outlined above. I understand that I may have a written copy to take with me upon my request.

Authorization to Treat & Bill

I give consent for the above named Patient to be treated by UCE. I authorize the release of any medical and demographic information necessary to process all claims. I authorize payment of medical benefits to UCE for all services performed and billed by UCE. UCE will submit a claim for service rendered to my insurance carrier and they do so as a courtesy. I understand that if I do not provide complete and accurate billing / insurance information at the time of service and this prevents UCE from collecting from my insurance company, I will be responsible for the full charges. I understand I will be held responsible for any balances that remain on the account after the insurance company has paid according to contract.

Cash Pay Patients

I understand that if I choose to be treated as a cash pay patient and I choose not to use or have no other form of insurance as a form of payment, the payment will be due at the time the services are rendered. I understand that a 30% discount will be applied for medical services provided.

Waiver of Outside Laboratory & Radiologists

I understand that UCE may send lab specimens to an outside laboratory or send x-rays taken by UCE to an outside Radiologist for over-reading. I give permission to bill my insurance for their services. I understand that I may incur additional charges as a result and I understand that UCE is not responsible for payment to those laboratories or radiologists.

Waiver for Non Contracted and Out of Network Insurance Companies

It is my understanding if UCE is not contracted or my insurance is out of network I may incur a higher out of pocket, meaning that my patient portion may be higher. If my insurance denies my claim for non-contracted services I will be responsible for all balances due.

Waiver for Non Covered Services

It is my understanding that my insurance company may deem all or part of my visit as a non-covered service. I will be responsible for payment for any and all services denied as non-covered.

On Site Prescription Program

UCE participates in an on-site prescription program and stocks a small quantity of routine prescriptions. I understand that the option is available to me to have my prescription filled / purchased from UCE. UCE does not participate in prescription insurance programs; therefore, UCE will not bill prescriptions to your insurance plan. If you bill your insurance program for prescriptions filled at UCE, you may or may not be reimbursed. UCE will not refund any prescriptions for any reason.

**By signing this form, I am only acknowledging that I have read and understand the policies above.
I also understand that not all of the policies may apply to me (or patient if minor).**

Patient Name:

Parent/Guardian Name (For Minors Only):

Signature:

Relationship to Patient:

Date:

Family Medical History							
	Asthma	Cancer	Deceased	Diabetes	Heart Disease	High Blood Pressure	None
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Siblings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Personal Medical History				<input type="checkbox"/> None
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Cancer	<input type="checkbox"/> Hyperlipidemia	<input type="checkbox"/> Prostate Disease	
<input type="checkbox"/> Anxiety	<input type="checkbox"/> COPD	<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> Psychiatric Disease	
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Depression	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Seasonal Allergies	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Migraines	<input type="checkbox"/> Seizures	
<input type="checkbox"/> Back Pain	<input type="checkbox"/> GERD/Ulcers	<input type="checkbox"/> Obesity	<input type="checkbox"/> Sinusitis	
<input type="checkbox"/> Blood Clot	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Sleep Disorders	
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Urine Infections	
History of Smoking? <input type="checkbox"/> Yes <input type="checkbox"/> No		History of Alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Current Smoker? <input type="checkbox"/> Yes <input type="checkbox"/> No		Current Alcoholic? <input type="checkbox"/> Yes <input type="checkbox"/> No		
History of Overseas Travel? <input type="checkbox"/> Yes <input type="checkbox"/> No		Occupation:		
Hobbies:				

Current Medications (Prescription, Over the Counter, Supplement)		<input type="checkbox"/> None

Current Symptoms (Regarding Today's Reason for Visit Only)		
Constitutional	Eyes	Ears
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Contacts	<input type="checkbox"/> Drainage
<input type="checkbox"/> Fever/Chills	<input type="checkbox"/> Discharge	<input type="checkbox"/> Foreign Object
<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Eye Glasses	<input type="checkbox"/> Hearing Changes
<input type="checkbox"/> Sweating	<input type="checkbox"/> Floaters	<input type="checkbox"/> Pain
<input type="checkbox"/> Trouble Sleeping	<input type="checkbox"/> Foreign Body	<input type="checkbox"/> Plugged
<input type="checkbox"/> Weakness	<input type="checkbox"/> Itchy	
<input type="checkbox"/> Weight Change	<input type="checkbox"/> Pain	
	<input type="checkbox"/> Redness	
	<input type="checkbox"/> Vision Changes	

Nose/Sinus <input type="checkbox"/> Bleeding <input type="checkbox"/> Congestion <input type="checkbox"/> Discharge <input type="checkbox"/> Facial Pain <input type="checkbox"/> Foreign Object <input type="checkbox"/> Sinus Pressure	Mouth <input type="checkbox"/> Gum Bleeding <input type="checkbox"/> Halitosis <input type="checkbox"/> Sores <input type="checkbox"/> Taste <input type="checkbox"/> Tooth Pain	Throat <input type="checkbox"/> Hoarseness <input type="checkbox"/> Pain when Speaking <input type="checkbox"/> Pain when Swallowing <input type="checkbox"/> Throat Pain
Cardiovascular <input type="checkbox"/> Chest Pain <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Foot/Leg Swelling <input type="checkbox"/> Palpitations	Respiratory <input type="checkbox"/> Cough <input type="checkbox"/> Coughing Blood <input type="checkbox"/> Pain with Breathing <input type="checkbox"/> Short of Breath <input type="checkbox"/> Sputum/Mucous <input type="checkbox"/> Wheezing	Gastrointestinal <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Anal Discomfort <input type="checkbox"/> Appetite Changes <input type="checkbox"/> Blood in Stool <input type="checkbox"/> Constipation <input type="checkbox"/> Dark/Black Stool <input type="checkbox"/> Diarrhea <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Hernia <input type="checkbox"/> Heart Burn <input type="checkbox"/> Jaundice <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting
Genitourinary <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Genital Pain/Sores <input type="checkbox"/> Incontinence <input type="checkbox"/> Irregular Periods <input type="checkbox"/> Menopause <input type="checkbox"/> Nighttime Urination <input type="checkbox"/> Pain/Burn Urination <input type="checkbox"/> Painful Periods <input type="checkbox"/> Testicular Pain <input type="checkbox"/> Testicular Swelling <input type="checkbox"/> Urinary Urgency <input type="checkbox"/> Birth Control Pills <input type="checkbox"/> Genital Discharge	Musculoskeletal <input type="checkbox"/> Arthritis <input type="checkbox"/> Injury <input type="checkbox"/> Pain <input type="checkbox"/> Swelling	Neurological <input type="checkbox"/> Convulsion/Seizures <input type="checkbox"/> Coordination <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Head Ache <input type="checkbox"/> Paralysis <input type="checkbox"/> Sensation Problems <input type="checkbox"/> Slurred Speech <input type="checkbox"/> Weakness
Psychological <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Memory Loss <input type="checkbox"/> Mood Changes <input type="checkbox"/> Phobias <input type="checkbox"/> Smoking	Skin/Hair/Nails <input type="checkbox"/> Hair Changes <input type="checkbox"/> Insect Bite/Sting <input type="checkbox"/> Itching <input type="checkbox"/> Lacerations/Injury <input type="checkbox"/> Nail Problems <input type="checkbox"/> Rashes <input type="checkbox"/> Sores	Hematology <input type="checkbox"/> Coumadin/Heparin Therapy <input type="checkbox"/> Easy Bruising <input type="checkbox"/> Lymph Node Swelling <input type="checkbox"/> Lymph Node Pain <input type="checkbox"/> Slow Blood Clotting
Allergic/Immunologic <input type="checkbox"/> Asthma <input type="checkbox"/> Eczema <input type="checkbox"/> Hives <input type="checkbox"/> Seasonal Allergies	Endocrine <input type="checkbox"/> Diabetes <input type="checkbox"/> Excessive Thirst <input type="checkbox"/> Goiter <input type="checkbox"/> Hot/Cold Intolerance <input type="checkbox"/> Hormone Therapy	Notes/Other

\$\$\$: _____	Patient Details					Account #: _____
FO Initials: _____						Arrival Time: _____
Last Name	First Name	Initial	Date of Birth	Age	Date	

Reason for Visit	Insurance Type	Insurance Company
	<input type="checkbox"/> Self Pay <input type="checkbox"/> Worker Comp <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> HMO <input type="checkbox"/> Medicare <input type="checkbox"/> Medicare Managed Care <input type="checkbox"/> AHCCCS	

Room #: _____	Patient Vitals (Urgent Care Express Use Only)					Triage Time: _____
						BO Initials: _____
Duration	Medication Allergies	Current Medications	Last Dose	Last Tetanus	Exposures	Pain Scale
						____ / 10

Weight	Height	Temperature	Respirations	Blood Pressure	Pulse Rate	Pulse Ox	LMP	Visual Acuity	<input type="checkbox"/> Glasses	<input type="checkbox"/> Contacts
____ lbs	____ inches	____ E O R A		____ / ____	____ bpm	____ %		Left ____/20	Right ____/20	Both ____/20

Labs/Studies							
Rapid Flu	<input type="checkbox"/> Positive A		<input type="checkbox"/> Positive B		<input type="checkbox"/> Negative		
Rapid Strep	<input type="checkbox"/> Positive			<input type="checkbox"/> Negative			
RSV	<input type="checkbox"/> Positive		<input type="checkbox"/> Negative				
Pregnancy	<input type="checkbox"/> Positive		<input type="checkbox"/> Negative				
Glucose	Last Meal						
Peak Flow							
EKG							
UA	Urob	Norm	2	4	8		
Glue	Neg	50	100	250	500	1000	
Ket	Neg	TR5	+15	++40	+++80	++++160	
Biliru	Neg	+		++		+++	
Prot	Neg	Tr	+30	++100	+++300	++++2000	
Nit	Positive			Negative			
LE	Neg	Tr		+	++	+++	
Blood	Neg	Tr	Mod	Tr	+SM	++Mod	+Lg
pH	5	6	6.5	7	8	9	
SG	1.000	1.005	1.010	1.015	1.020	1.025	1.030
Time:	BO Initials:						

Radiology	
Type	<input type="checkbox"/> Chest (PA/Lat) <input type="checkbox"/> Hand 3V <input type="checkbox"/> Clavicle <input type="checkbox"/> Finger <input type="checkbox"/> Shoulder <input type="checkbox"/> Femur (RT Only) <input type="checkbox"/> Humerus <input type="checkbox"/> Knee 3V <input type="checkbox"/> Elbow 3V <input type="checkbox"/> Tib-Fib <input type="checkbox"/> Forearm <input type="checkbox"/> Ankle 3V <input type="checkbox"/> Upper Extremity <input type="checkbox"/> Foot 3V <input type="checkbox"/> Wrist <input type="checkbox"/> Toes <input type="checkbox"/> Left <input type="checkbox"/> Right
Preliminary Report	
<input type="checkbox"/> No masses, infiltrates or consolidations identified. <input type="checkbox"/> No obvious fracture or dislocation identified. <input type="checkbox"/> Other:	
Time:	BO Initials:
Provider	
Prescription <input type="checkbox"/>	Send X-rays <input type="checkbox"/>
InstyMeds <input type="checkbox"/>	Note Signed <input type="checkbox"/>
Outside Referral <input type="checkbox"/>	Note Scanned <input type="checkbox"/>
Signature	

Notes

Other Orders		
	Time:	BO Initials: