Affinity Immediate Care

PATIENT REGISTRATION

Please fill out the entire form **DATE:** ____________

Reason for your visit today: ____________

Is this visit related to a motor vehicle accident or work-related injury: __Yes __No DOI:____________

PATIENT INFORMATION

First Name: ____________ Last Name: ____________ MI: ___

Date of Birth: __ / __ / __ Social Security Number:___ / __ /______ Male ___ Female ___

Marital Status: ___ Married ___ Single ___ Divorced ___ Widowed ___ Legally Separated ___ Other

Address: ____________

City: ____________ State: ____________ ZIP: ________

Telephone: Home: ____________ Mobile: ____________ Work: ____________

May we contact you at work: ___ Yes ___ No

Employer: ____________ Phone: ____________

Emergency Contact: ____________ Relationship: ______ Phone: ____________

Email Address: ____________

By providing Affinity Immediate Care with your email address you agree to receive periodic updates via email regarding our services and those of other Affinity-related properities, including Affinity Laser + Med Spa. Affinity Immediate Care takes protecting your personal information seriously and never shares, sells or distributes your email address to third parties.

How did you hear about us: Referral__ If so, who?: ____________ Website__ Advertisement __

Would you like today's prescription sent via e-Fax? If so, please provide the following information:

Pharmacy Name: ____________

Phone: ____________

Affinity Immediate Care

PATIENT REGISTRATION

Name: ______________________ Date of Birth: ____________

PRIMARY/SECONDARY INSURANCE INFORMATION (Provide your insurance cards to the front desk)

Name of Subscriber: ______________________ Relationship to Patient: ____________

Primary Insurance Co: ______________ ID#: __________ Group #: __________

Subscriber DOB: ___ /___ / ___ Subscriber Social Security Number: ___ /___ /______

Secondary Insurance Co: ______________ ID#: __________ Group #: __________

Subscriber DOB: __ /__ /__ Subscriber Social Security Number: ___ /__ /______

Primary Care Physician: ______________________ Phone: ______________

I have a received a copy of the Privacy Policies: ___ Yes ___ No

Name: ______________________________ Date: __________

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or responsible party) Signature: ______________________ Date: __________

SURGERY HISTORY (include any major surgeries or other injuries we may need to know about):

____

____

____

CURRENT MEDICATIONS (include prescription, over-the-counter, and herbals):

Name of Medicine	Dose	How often taken	Time last taken	Reason for taking	Length of time taken

Affinity Immediate Care

PATIENT REGISTRATION

Name: ______________________ Date of Birth: ______________

MEDICAL HISTORY

Please circle ALL previous illnesses or conditions below: [P] Past History [F] Family History

HEART AND BLOOD VESSELS
- [P] [F] Heart failure
- [P] [F] High blood pressure
- [P] [F] Heart attack
- [P] [F] Poor circulation
- [P] [F] Stroke
- [P] [F] High cholestrol / lipids
- [P] [F] Irregular heart beat
- [P] [F] Valvilar disease

KIDNEY / BLADDER
- [P] [F] Stones
- [P] [F] Kidney failure/History of dialysis
- [P] [F] Recurring Urinary Tract Infection

LIVER
- [P] [F] Hepatitis
  - ☐ Hepatitis A
  - ☐ Hepatitis B
  - ☐ Hepatitis C
  - ☐ Don't know status
- [P] [F] Cirrhosis

GENITOURINARY - Female Only
- [P] [F] Recurring Vaginal Infection
- [P] [F] Menopause
- [P] [F] Uterine fibroids
- [P] [F] Dysfunctional bleeding
- [P] [F] Polycystic Ovarian Syndrome
- [P] [F] Sexual dysfunction
- [P] [F] Sexually transmitted disease
- [P] [F] Endometriosis
- [P] [F] Urinary incontinence

BLOOD DISORDERS
- [P] [F] Anemia
- [P] [F] Sickle cell anemia
- [P] [F] Bleeding disorder
- [P] [F] History of blood transfusions
- [P] [F] Clot
- [P] [F] Myelodysplastic disorder

ENDOCRINE (glands)
- [P] [F] Tyroid disease
- [P] [F] Diabetes
- [P] [F] Pituitary disease
- [P] [F] Adrenal disease

JOINTS / SKELETON
- [P] [F] Osteoporosis
- [P] [F] Fractures
- [P] [F] Arthritis
- [P] [F] Gout
- [P] [F] Scoliosis

SOCIAL
- [P] [F] Alcohol Abuse
- [P] [F] Illicit Drug Abuse
- [P] [F] Smoking Tobacco Use
- [P] [F] Oral Tobacco Use
- [P] [F] Second hand smoke exposure

GENITOURINARY - Male Only
- [P] [F] Prostate Problems
- [P] [F] Disorders of the testes
- [P] [F] Sexual dysfunction
- [P] [F] Sexually transmitted disease
- [P] [F] Urinary incontinence

LUNGS
- [P] [F] Emphysema
- [P] [F] Asthma
- [P] [F] Hay Fever
- [P] [F] Chronic bronchitis
- [P] [F] Tuberculosis
- [P] [F] Asbestosis
- [P] [F] Pneumonia
- [P] [F] Pulmonary embolism *(lung blood clot)*
- [P] [F] Sleep apnea
- [P] [F] Home Oxygen

SKIN DISORDERS
- [P] [F] Acne
- [P] [F] Eczema
- [P] [F] Psoriasis
- [P] [F] Warts
- [P] [F] Shingles

PSYCHOLOGICAL/PSYCHIATRIC
- [P] [F] Depression
- [P] [F] Anxiety
- [P] [F] Schizophrenia
- [P] [F] Phobias
- [P] [F] Addiction

GENETIC DISEASES
- [P] [F] Breast / Ovarian (BROV)
- [P] [F] Cowden Syndrome
- [P] [F] Familial Adenomatous Polyposis
- [P] [F] Hereditary Breast Cancer
- [P] [F] Nonpolyposis Colon Cancer
- [P] [F] Peutz-Jagher
- [P] [F] Li-Fraumeni

STOMACH / INTESTINES
- [P] [F] GERD
- [P] [F] Ulcers
- [P] [F] Crohn's Disease
- [P] [F] Colitis
- [P] [F] Diverciulitis
- [P] [F] Diverticulosis
- [P] [F] Irritable bowel syndrome
- [P] [F] Polyps
- [P] [F] Gallstones
- [P] [F] Pancreatitis

BRAIN AND NERVES
- [P] [F] Headaches or migraines
- [P] [F] Neuropathy *(peripheral nerve disease)*
- [P] [F] Parkinson's
- [P] [F] Dementia / Alzheimer's
- [P] [F] Seizures
- [P] [F] Meningitis
- [P] [F] Multiple sclerosis
- [P] [F] Chronic fatigue syndrome

IMMUNE SYSTEM
- [P] [F] HIV / AIDS
- [P] [F] Frequent infections
- [P] [F] Lupus
- [P] [F] Rheumatoid arthritis

OTHER MEDICAL HISTORY
- [P] [F] ______________
- [P] [F] ______________
- [P] [F] ______________

ALLERGY INFORMATION

Please circle ALL previous illnesses or conditions below:

DRUG ALLERGIES
- ☐ Ibuprofen (Motrin)
- ☐ Acetylsalicylic acid (Asprin)
- ☐ Hydrocodone/Acetaminophen
- ☐ Hydrocodone (Vicodin/Lortab)
- ☐ Codeine
- ☐ Morphine
- ☐ Penicillin
- ☐ Neosporin
- ☐ Benadryl
- ☐ Statins
- ☐ Steroids
- ☐ ACE Inhibitors

DRUG ALLERGIES (continued)
- ☐ Ketorolac (Toradol)
- ☐ Rofecoxib (Vioxx)
- ☐ Amoxicillin / clavula (Augmentin)
- ☐ Clarithromycin (Biaxin)
- ☐ Clindamycin (Cleocin)
- ☐ Erythromycin (Erythrocin)
- ☐ Metronidazole (Flagyl)
- ☐ Co-trimoxazole (Bactrim)
- ☐ IV contrast media
- ☐ Other: ______________

CONTACT ALLERGIES
- ☐ Latex
- ☐ Alcohol
- ☐ Betadine
- ☐ Bandaids
- ☐ Covaderm (woven fabric tape)
- ☐ Coverlet (paper tape)
- ☐ Duoderm (collagen)
- ☐ Elastoplast tape
- ☐ Plastic tape
- ☐ Other: ______________

FOOD ALLERGIES
- ☐ All seafood
- ☐ Corn
- ☐ Egg
- ☐ Milk protein(s)
- ☐ Peanuts
- ☐ Shellfish only
- ☐ Soy protein(s)
- ☐ Tree nuts
- ☐ Banana
- ☐ Other: ______________

Patient Consent Form

Please Read and Sign

I, the undersigned, hereby consent to the following:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that Affinity Immediate Care, LLC may include consent at satellite offices under common ownership.

I, the undersigned, acknowledge that Affinity Immediate Care, LLC will use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

I give permission for Affinity Immediate Care, LLC to disclose my health information to the individual/s listed below:

________________________________ ________________________________

________________________________ ________________________________

Medicare Patients

I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Affinity Immediate Care, LLC. I acknowledge that I have been given the Affinity Immediate Care, LLC Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official.

Patient Initial: _________________

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

____ ________________________

Patient (or Responsible Party) Signature Date