Account #: _____

DOCTORS URGENT CARE

PATIENT REGISTRATION FORM

Last Name: _____ First Name: _____ Middle Initial: _____

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Date of Birth: _____ Gender: **M F** Marital Status: **M S D W X** SSN: _____

Please Circle One

Employment Status: **A. Military** **Disabled** **Full Time** **Part Time** **Self Employed** **Retired** **Student**

Employer Name: _____

Please Circle One

Language: English Spanish Other **Ethnicity:** Hispanic or Latin Not Hispanic Refuse to Report

Race: (**W**) White / (**B**) African American / (**A**) Asian / (**N**) American Indian or Alaska Native / (**P**) Native Hawaiian or Pacific Islander / (**O**) Other or Multi-Racial / (**U**) Unknown / (**D**) Refuse to Report

RESPONSIBLE PARTY INFORMATION

Father Name: _____
Mailing Address: _____
City/State/Zip: _____
Home Ph: _____ Work Ph: _____
Cell Ph: _____ Date of Birth: _____
Social Security #: _____

Mother Name: _____
Mailing Address: _____
City/State/Zip: _____
Home Ph: _____ Work Ph: _____
Cell Ph: _____ Date of Birth: _____
Social Security #: _____

INSURANCE INFORMATION

PRIMARY INSURANCE

Ins Company: _____
Relationship to Insured: Self Child Mate Other
Policy #: _____
Policy Holder's Name: _____
Policy Holder's SS #: _____
Policy Holder's DOB: _____

SECONDARY / SUPPLEMENTAL

Ins Company: _____
Relationship to Insured: Self Child Mate Other
Policy #: _____
Policy Holder's Name: _____
Policy Holder's SS #: _____
Policy Holder's DOB: _____

I understand that current & valid insurance is necessary for reimbursement, unless I choose to pay for the service myself. This information, as well as personal mailing information, will be verified in writing and signed by the patient/responsible party before every office visit. I understand that having medical insurance does not release me from my financial liability to Doctors Urgent Care. It is ultimately my responsibility for payment of all charges for services rendered. This also includes workman's compensation patients. I authorize payment of medical benefits to Doctors Urgent Care.

All refunds over $20 due to the patient will be processed after the insurance payment is posted to the account, $20 or less will be applied as a credit on the account(s).
Doctors Urgent Care reserves the right to turn over any patient balance due to an outside collection agency and or an attorney.
I further understand that a $25 fee will be charged for returned checks. This returned check and NSF fee must be paid in cash, credit card, or money order within 30 days of receipt of written notification from Doctors Urgent Care, LLC.

I acknowledge that I have the right to request a copy of the current HIPPA Privacy Notice effective 9-23-13 or later.

Signature of Patient/Responsible Party/Guardian: _____ Date: _____

DOCTORS' URGENT CARE
985 ROBERT BLVD, STE: 101
SLIDELL, LA 70458

Date: _____

Account #: _____

PATIENT MEDICATION/ALLERGY AND VISIT INFORMATION

Name: _____ Cell Phone: _____

Why are you being seen today? _____

Have you traveled outside of the United States in the last 1 month? YES NO
Have you been in close contact with somebody diagnosed or possibly having COVID19? YES NO
Is this a Motor vehicle accident? YES NO
Is this a Work Related injury? YES NO
If yes, Date of Injury?_____
Are you allergic to latex? YES NO
Are you breastfeeding? YES NO
Are you possibly pregnant? YES NO

VACCINES: Check one box for each vaccine:

Pneumonia	Influenza (Flu)	Tetanus
❑ Within past 5 years	❑ Within the past year	❑ Within the past 10 years
❑ No	❑ No	❑ No
❑ Unknown	❑ Unknown	❑ Unknown

ALLERGIES: Are you allergic to medications, iodine, food or tape?

Allergy	Reaction	Allergy	Reaction

MEDICATIONS: Please list all prescription medication, over the counter medication, vitamin and nutritional supplements that you currently use.

Name of Medicine	Dose (Such as 50 mg)	Route (Oral, Drops, Inhalation, Injection, Skin or Spray)	Directions (How do you take it? Ex: 1 in a.m.)	Purpose? Why do you take it?	Taken Today? Check Box if yes.
					❑
					❑
					❑
					❑
					❑
					❑
					❑
					❑

PATIENT (OR RESPONSIBLE PARTY) SIGNATURE: _____

DOCTORS URGENT CARE LLC
MEDICAL TREATMENT CONSENT FORM

PATIENT NAME: _____

Consent for treatment: Knowing that I (or the patient indicated on the top of this form) desire evaluation and/or treatment at Doctors Urgent Care LLC, or Doctors Urgent Care Associates LLC, I voluntarily consent to such care. I consent to routine diagnostic procedures, including but not limited to x-rays, blood draw, laboratory tests, administration of medication and to medical or surgical treatment by physicians and staff members of Doctors Urgent Care LLC and/or Doctors Urgent Care Associates LLC and other health care providers who may be called upon to consult or assist in my care as judged necessary by my treating physician. I am aware that the practice of medicine is not an exact science and I acknowledge that no guaranties have been made to me as to the results of my examination or treatment at Doctors Urgent Care LLC or Doctors Urgent Care Associates LLC. I acknowledge that treatment at Doctors Urgent Care LLC or Doctors Urgent Care Associates LLC is intended to address specific episodic illnesses or injury and is not intended to substitute for comprehensive care in lieu of a primary care physician or other specialized physician. In order to provide the best chance for successful treatment I accept responsibility to follow the advice of my treating physician including compliance with medications, discharge instructions and re-evaluation with follow up or referral physicians. I agree to return to the clinic or seek care in an Emergency Department of a hospital if my condition substantially changes. I further agree to hold harmless the physicians and staff of Doctors Urgent Care LLC or Doctors Urgent Care Associates LLC should I fail to comply with the above conditions.

Patients at Doctors Urgent Care LLC and Doctors Urgent Care Associates LLC will be treated regardless of race, color, age, national origin, disability or religion. Notwithstanding the above criteria, Doctors Urgent Care LLC and Doctors Urgent Care Associates LLC reserves the right to refuse care to any individual who may have an unpaid balance, exhibits rude or disruptive behavior or any other reason at the discretion of the physician on duty.

This consent shall remain in force until such time as it is specifically revoked.

Signature of patient or patient
representative: _____ Date: _____
(Representative signature required if the patient is a minor or unable to consent)
Representative's relationship to patient: _____
Patient is unable to consent because: _____
Witness: _____