MedStar Health

EMERGENCY SCREENING REGISTRATION FORM

Patient Name:_____ Date of Birth: _____
Last First Middle Initial

Marital Status:_____ Gender:_____ Race:_____ Employment Status:_____

Address: _____
City State Zip code

Phone Number:_____ Email: _____

How did you hear about us?_____ Preferred Pharmacy: _____

Policy holder of insurance:_____ Relationship:_____ DOB:_____

***REASON FOR YOUR VISIT TODAY:** _____

Is today's visit related to work place injury? ❑ Yes ❑ No
Is today's visit related to an auto accident? ❑ Yes ❑ No
Have you (or the patient) traveled recently? ❑ Yes ❑ No If yes: **Date:**_____ **Location:** _____

IF YOU (OR THE PATIENT) ARE EXPERIENCING ANY OF THE FOLLOWING AT THIS TIME PLEASE CIRCLE THE BOLDED SYMPTOM/EVENT:

Staff Reviewed
Initials:_____
Time:_____
Placed in Mask
Y or N (circle)

1. **Chest pain** (not associated with coughing or flu symptoms), **pressure or heaviness in the chest with pain that radiates into the shoulder, arm, back, jaw** or **heart attack symptoms**
2. **Difficulty breathing** or **asthma attack**
3. **Bleeding-** severe or uncontrolled
4. **Fainting** or **seizure** or **loss of consciousness**
5. **Foreign object in the eye** or **chemicals splashed in the eye**
6. **Overdose** or **ingestion of a chemical**
7. **Stroke** symptoms, **sudden onset of one-sided extremity or facial weakness**, or **difficulty speaking** or **blurred vision** or **dizziness** or **worst headache of life** or **confusion, disorientation**
8. **Rash** possibly contagious (such as chickenpox, scabies, measles)
9. **Head injury from fall, injury, motor vehicle crash** or **neck pain, headache from fall, injury, motor vehicle crash** or **numbness, weakness, tingling in the extremities**
10. **Severe abdominal pain** or **testicular pain** or **pregnancy with severe abdominal pain**

_____

_____ _____ _____
Signature Date Time

_____ _____
Name of Representative Signing for Patient Relationship of Representative to Patient
(Required if the patient is a minor or an adult unable to sign this form)

STAFF USE ONLY IF NEEDED IN AN EMERGENCY

Vital Signs: BP:_____/_____ Height:_____cm Weight:_____kg Pain: _____

Temp:_____C Pulse: _____ Resp: _____ SpO2:_____% Time: _____ Initials: _____

02-20-2021 wkm

MedStar Health

MEDSTAR HEALTH URGENT CARE PATIENT HISTORY FORM

Patient's Full Name:_____ **Date of Birth:** _____

MEDICAL, FAMILY, SOCIAL HISTORY:

Medication/Drug Allergies: _____

Current Medications: _____

_____

Have You Been Diagnosed With Any of the Following (*Check All That Apply*):

- ❑ Heart Disease
- ❑ Anxiety Or Depression
- ❑ Asthma Or COPD/Emphysema
- ❑ Diabetes
- ❑ Cancer: (*Type*) _____
- ❑ Gastrointestinal (GI) Bleeding
- ❑ High Blood Pressure (Hypertension)
- ❑ Seizure Disorder
- ❑ Stroke

Any Other Medical History: _____

Any History of Surgery:_____

Family History – Father/Mother/Brother/Sister (*Check All That Apply*):

- ❑ Cancer who:_____
- ❑ Heart Disease who:_____
- ❑ Diabetes Mellitus who:_____
- ❑ Hypertension who:_____

For Females (of Childbearing Age): Last Menstrual Period:_____**Birth Control** ❑ Yes ❑ No (*Type*) _____

For Children: Is Your Child Up to Date on Vaccinations? ❑ Yes ❑ No

Tobacco Use: ❑ Yes ❑ No **Alcohol Use:** ❑ Never ❑ Rarely ❑ Occasional ❑ Heavy

Completed By: ❑ Patient ❑ Parent/Guardian/Other **Signature:** _____

Print Name Here if Parent/Guardian/Other: _____

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MedStar Health

PATIENT NAME: _____ **PATIENT DOB:** _____

CONSENT FOR MEDICAL TREATMENT

I hereby authorize the personnel and providers of this medical facility to render such care as they deem necessary and appropriate in their professional judgment.

I understand that I have the right to make informed decisions regarding all care and treatment, and that I should ask the personnel of this medical facility to clarify any details of my care that I do not understand. This includes the right to refuse treatments I do not want.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize this medical facility to release any medical information deemed necessary to the identified third party payers and/or legitimate agents of the listed parties to determine benefits payable.

ASSIGNMENT OF BENEFITS

I hereby authorize direct payment of any insurance, personal injury protection, or other benefits payable to me.

GUARANTEE OF PAYMENT

I acknowledge financial responsibility for any health insurance deductible, coinsurance or failure for any reason of any insurance carrier to pay the medical facility or practice's charges in full when rendered. I also acknowledge that interest may be charged to unpaid balances over thirty days from the date payment is due. In the event that the account is referred to collection, I agree to pay all reasonable collection and attorney fees required to collect any delinquent balance.

I understand that, if my provider determines it is clinically indicated, I may have a telehealth consultation with an Emergency Medicine specialist. I understand that it is a separate visit from my Urgent Care visit and that I will receive a separate physician bill.

PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION (MEDICARE and MEDICAID PATIENTS ONLY)

I hereby certify that the information given by me applying for payment under TITLE XVIII (Medicare) and XIX (Medicaid) of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claim.

PATIENT RIGHTS AND RESPONSIBILITIES

By signing below, I acknowledge that I have received information about Patients' Rights and Responsibilities.

NOTICE OF PRIVACY PRACTICES

My initials acknowledge that I received the MedStar Health Privacy Practices Brochure.

_____ Initials

☐ Patient/Patient Representative declined to acknowledge

☐ Patient/Patient Representative unable/unwilling to acknowledge receipt

I certify that I have read, understand, and agree to the terms and conditions of this form and that I am authorized as the patient or the patient's representative to sign this document and be bound by its terms.

_____ Patient's Signature

_____ Date

_____ Time

If Patient is under 18 years old or unable to sign:

_____ Authorized Person's Signature

_____ Date

_____ Time

MedStar Health

AUTOMOBILE OR WORK INJURY

Please complete this form if the reason for today's care is an automobile accident or an injury at work **and** this is the first time you are being seen by MedStar Heath Urgent Care for this particular injury.

PATIENT - ACCIDENT INFORMATION

Patient Name:_____ Today's Date: _____

Social Security Number:_____ Date of Accident: _____

State Where Accident Occurred: _____

INSURANCE INFORMATION

Insurance Company Name: _____

Employer Name (work injury only):_____

Employer Address:_____

Claim Number: _____

Contact/Adjuster Name:_____ Phone Number: _____

Billing Address: _____

_____

The information on this form is correct to the best of my knowledge.

Signature:_____ Date: _____