STATMED QUICK QUALITY URGENT CARE
REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	(Former Name)	Social Security no.:	Birth date: / /	Age:	Sex: ❑ M ❑ F	Race:

Street address:	Home phone #: ( )

P.O. box:	City:	State:	ZIP Code:	Employer phone #: ( )

Occupation:	Employer:	Cell phone #: ( )

Pharmacy:	Phone:
Address or Intersection:	

Chose clinic because/Referred to clinic by (please check one):	❑ Dr.	❑ Billboard	❑ TV Commercial	❑ Internet

❑ Family/Friend	❑ Close to home/work	❑ Yellow Pages	❑ Advertisement Where?	Other

Other family members seen here:	**Email:**

INSURANCE INFORMATION

(Please give your insurance card and Driver's License to the receptionist)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance	❑ United Healthcare	❑ Aetna	❑ Blue Cross Blue Shield	❑ Humana	❑ Medicare

❑ Cigna	❑ Great West	❑ AvMed	❑ Tricare	❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone #: ( )	Cell phone #: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

PAST MEDICAL / SURGICAL HISTORY

NAME: _____ DATE:____/____/_____

HEIGHT: _____ WEIGHT:_____

NAME OF YOUR PRIMARY CARE PHYSICIAN_____

PHARMACY NAME / LOCATION: _____

REASON FOR VISIT:_____

WHEN DID SYMPTOMS OCCUR? _____

IS THIS VISIT DUE TO A WORK RELATED INCIDENT? ____YES ____NO

MARITAL STATUS: _____SINGLE _____MARRIED _____DIVORCED

DO YOU LIVE WITH ANYONE OTHER THAN YOURSELF: ____YES ____NO
IF YES: ____SPOUSE _____FAMILY ____ROOMATE

OCCUPATION: _____

DO YOU HAVE ALLERGIES TO ANY MEDICATIONS? _____YES ____NO
(IF YES PLEASE LIST MEDICATION AND REACTION)

ALLERGIES:

MEDICATION NAME	REACTION
_____	_____
_____	_____
_____	_____
_____	_____

PRESCRIPTION MEDICATIONS:

MEDICATION NAME	DOSE (mg)	FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient's Name:_____

*******Please check what DOES apply********

	YES	NO
IMMUNIZATIONS:		
Flu shot		
Last Tetanus shot		
SURGERIES:		
Appendectomy		
C-Section		
Gallbladder		
Heart By Pass		
Hysterectomy		
Orthopedic		
Stents		
Tonsils		
List OTHER surgeries below		
CANCER:		
Breast		
Colon		
Lung		
Ovaries		
Prostate		
Skin (Type)		
HEART:		
Angina		
Cholesterol		
Congestive Heart Failure		
Coronary Artery Disease		
Heart Attack		
High Blood Pressure		
Eye:		
Cataracts		
Glaucoma		
Genitourinary:		
Kidney Stones		
Renal Disease		
Sexually Transmitted Disease		
GI:		
Hepatitis		
Pancreatitis		
Reflux		
Ulcer		
Crohn's		
IBS		
Diverticulitis		
ENDOCRINE:		
Diabetes		
Thyroid		

	YES	NO
Are you pregnant?		
Last Menstrual Period		
Are you Menopausal?		
MEDICAL SERVICES/ IMPLANTS:		
AICD		
Ports		
Pacemaker		
Joint Replacement		
BONES:		
Arthritis		
Fibromyalgia		
Osteoporosis		
NEUROLOGICAL:		
Migraines		
Seizures		
Stroke		
TIA		
PSYCHIATRIC/ SOCIAL:		
Anxiety		
Bipolar		
Depression		
RESPIRATORY:		
Asthma		
Bronchitis		
COPD		
Pneumonia		
Tuberculosis		
OTHER:		
Sickle Cell		
AIDS		
Anemia		
HIV		
ALCOHOL USE:		
Frequency- (None/Daily/Social/Alcoholic)		
TOBACCO USE:		
Never/ Former/Current- How many?		
FAMILY MEDICAL HISTORY:		
(Relationship to You)		
Cancer/ Type		
Cholesterol		
Diabetes		
Heart Disease		
High Blood Pressure		
Respiratory Problems		
Stroke		

MVA Information

Patient's Name: _____

Date of Birth: _____

Date of Accident: _____

Date of Service: _____

Insurance Name: _____

Insurance Address: _____
_____
_____

Insurance Phone Number: _____

Adjuster's Name: _____

Adjuster's Phone #: _____

Policy Number: _____

Claim # (if available): _____

Attorney's Name: _____

Attorney's Phone #: _____

Health Insurance to be billed as secondary?** Circle YES NO
If YES…please get a copy and full details of insurance carrier from patient (Copy of card and Insured information)

**Please note that it is not a guarantee that health policy will pick up any remaining balance and patient may end up with a balance once accidental policy gets billed.

ASSIGNMENT OF BENEFITS, LIENS, DIRECT PAYMENT AUTHORIZATION, AUTHORIZATION TO RELEASE INSURANCE INFORMATION, AND AUTHORIZATION TO ESCROW UNPAID MEDICAL & PIP BENEFITS

Statmed Quick Quality Clinic of North Pinellas, LLC

INSURANCE CARRIER: _____

CLAIM/POLICY NUMBER: _____ DATE OF LOSS: _____

For and in consideration of Statmed Quick Quality Clinic of North Pinellas, LLC. agreeing to pursue the responsible automobile insurance carrier for payment of benefits due and not requiring prepayment for services, I hereby irrevocably assign all (absolutely all) rights and benefits to Statmed Quick Quality Clinic of North Pinellas, LLC for Personal Injury Protection, extended Personal Injury Protection, Medical Payment Coverage, and other benefits which I may have in accordance with Florida Statute §627.736. This includes any benefits from my insurance company and any other entity which may be responsible for medical expenses incurred. I further authorize Statmed Quick Quality Clinic of North Pinellas, LLC to collect payments & prosecute any necessary actions to collect payment for services as they see fit and allowable by law and contract. THIS DOCUMENT CONSTITUTES AN ABSOLUTE ASSIGNMENT OF RIGHTS AND BENEFITS.

I hereby further give a lien to Statmed Quick Quality Clinic of North Pinellas, LLC against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by Statmed Quick Quality Clinic of North Pinellas, LLC as a result of the above stated loss date. This document acts as an irrevocable and absolute assignment of all of my rights and benefits under all policies of insurance for which I am entitled to coverage thereupon. I agree to cooperate with Statmed Quick Quality Clinic of North Pinellas, LLC and their attorneys (at their choosing), and to do all things reasonable to effect payment of the bills by the insurance company or other entity to Statmed Quick Quality Clinic of North Pinellas, LLC including, but not limited to, disclosing my medical condition, being available for factual discovery or other cooperation.

This assignment concerns the bills for Statmed Quick Quality Clinic of North Pinellas, LLC and those costs including, but not limited to, attorneys fees, other costs, and interest necessary in procuring payment from the above-named insurance company and/or other entities. This assignment is not intended to assign any other causes of action that may belong to the undersigned patient. I agree to pay any applicable deductible or co-payment not covered by any policy of insurance cited above. I understand that as a benefit and convenience to me, Statmed Quick Quality Clinic of North Pinellas, LLC will bill and pursue collection against the insurance company or other responsible entity on my behalf. I hereby instruct and direct my insurance company to pay my benefits directly to Statmed Quick Quality Clinic of North Pinellas, LLC at the address provided on the bill. If my current policy prohibits direct payment to doctors, then I hereby instruct and direct my insurance company or other responsible entity to make the check payable to me and mail it to Statmed Quick Quality Clinic of North Pinellas, LLC at the address on the bill. Statmed Quick Quality Clinic of North Pinellas, LLC's medical care is being provided for a reasonable fee for treatment causally related to the above loss date and is medically necessary. I instruct my insurance carrier or other responsible entity to pay these bills to the full extent of my available benefits under the insurance policy and Florida law. If any portion of the charge for these services is either reduced or denied in whole or in part, my insurance company or other entity is to place funds equal to the amount of the reduced or denied charges into escrow and hold the escrowed funds until agreement or resolution of legal action by Statmed Quick Quality Clinic of North Pinellas, LLC I further instruct my insurance company to make payment for charges submitted by Statmed Quick Quality Clinic of North Pinellas, LLC in priority to any other requests to escrow benefits, including a request by myself to reserve benefits for pending disability claims. I hereby give Statmed Quick Quality Clinic of North Pinellas, LLC limited power of attorney to endorse and sign my name on any draft for payment to either Statmed Quick Quality Clinic of North Pinellas, LLC or myself if said draft represents payment for charges related to services rendered by Statmed Quick Quality Clinic of North Pinellas, LLC.

I further direct my insurance carrier or responsible other entity to provide information to Statmed Quick Quality Clinic of North Pinellas, LLC which is otherwise available to me including but not limited to a copy of any applicable insurance policy, declaration page, all applicable endorsements, transcripts and/or copies of any recorded statements, examinations under oath and requests for same, independent medical evaluations and requests for same, peer review reports and listing of all PIP benefits paid to date which shall include when claim were made, when the claims were received, the payment or denial of each claim, the amount of the deductible and the claims applied thereto, and whether benefits have been exhausted and the amount of PIP benefits available, commonly known as a "PIP log". This request includes the name of other medical providers to whom payments have been made under my policy of insurance. This agreement is intended to serve as an assignment of rights and benefits under my policy of insurance in favor of Statmed Quick Quality Clinic of North Pinellas, LLC If any language within this agreement has the effect of invalidating this agreement, that language shall be deemed void and the remainder of the assignment shall maintain full force and effect. A photocopy of this assignment shall be considered as effective and valid as the original.

_____	_____	_____
Patient Signature	Date	Patient Name

If patient is incapacitated or under the age of 18, please indicate the patient name, guardian name and relation to patient, and obtain guardian signature.