STATMED QUICK QUALITY URGENT CARE
REGISTRATION FORM

(Please Print)

Today's date:			Primary Care Dr.:			
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: Address or Intersection:		Phone:				
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:		Birth date: / /	Subscriber's S.S. 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: ____/____/_____**

DOB: ____/____/_____ LAST 4 SSN: _____

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
IMMUNIZATIONS:	
Flu shot	
Last Tetanus shot	
SURGERIES:	
Appendectomy	
C-Section	
Gallbladder	
Heart Bypass	
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
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	

Surgical Clearance Information

Patient's Name: _____

Date of Birth: _____

Date of Accident: _____

Date of Service: _____

Attorney's Name:_____

Paralegal's Name:_____

Paralegal's Phone #:_____Fax#:_____

Paralegal's Email:_____

Paralegal's Address: _____

_____

BI/UM limits:_____

Health Insurance to be included in lien? Circle: YES NO
If YES…please get a copy and full details of insurance carrier from patient (Copy of card and Insured information)

Authorization for Provider Lien; Personal Guaranty of Payment; Authorization for Release of Information;

I grant Statmed Quick Quality Clinic at North Pinellas, LLC a lien against any recovery which I may have now or in the future against any tortfeasor or any responsible insurance carrier. I hereby direct that any attorney representing me now or in the future to execute this letter of protection in favor Statmed Quick Quality Clinic at North Pinellas, LLC. I hereby further give a lien on my case to Statmed Quick Quality Clinic at North Pinellas, LLC in an amount equal to the outstanding balance for services rendered to me by Statmed Quick Quality Clinic at North Pinellas, LLC. This lien shall be against any and all proceeds of any settlement, judgment or verdict which may be paid to my attorney or myself due to injuries for which I have been treated or injuries in connection therewith.

I hereby authorize Statmed Quick Quality Clinic at North Pinellas, LLC to furnish you, my attorney, with a full report of their examination of myself in regard to the accident in which I was involved.

I hereby guarantee full payment to Statmed Quick Quality Clinic at North Pinellas, LLC and agree that I will remain personally responsible for any unpaid charges resulting from deductible, co-payment, or treatment after benefits are exhausted.

I hereby authorize and direct any attorney in my past or present employ, to pay directly to Statmed Quick Quality Clinic at North Pinellas, LLC such sums as may be due and owing to them for professional services rendered to me both by reason of this accident and by reason of any other bills that are due to their office and to withhold such sums from any settlement, judgment or verdict as may be necessary adequately to protect Statmed Quick Quality Clinic at North Pinellas, LLC

I fully understand that I am directly and fully responsible to Statmed Quick Quality Clinic at North Pinellas, LLC for all professional bills submitted by Statmed Quick Quality Clinic at North Pinellas, LLC for services rendered to me and that this agreement is made solely for Statmed Quick Quality Clinic at North Pinellas, LLC additional protection and in consideration of their awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. Statmed Quick Quality Clinic at North Pinellas, LLC may at its discretion bill me directly at any time for any amounts then due and owing. I further agree to pay any amounts billed to me within ten (10) days of billing date. If I should fail to pay any amount Statmed Quick Quality Clinic at North Pinellas, LLC may put my account into collection, with the costs of collection, including a reasonable attorneys' fee, to be borne by me.

Any failure of Statmed Quick Quality Clinic at North Pinellas, LLC to avail itself of any of the protection afforded it under this agreement shall not constitute a waiver of that remedy.

Patient Name:_____Patient Signature:_____Dated: _____

The undersigned, as the lawfully retained attorney for the above patient, does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary adequately to protect Statmed Quick Quality Clinic at North Pinellas, LLC named above. Attorney shall withhold all amounts necessary to fully compensate Statmed Quick Quality Clinic at North Pinellas, LLC for services rendered to Patient, and shall not distribute funds received in settlement of Patients claim unless first satisfying Statmed Quick Quality Clinic at North Pinellas, LLC's full balance or receiving a written acceptance of less than the full amount from Statmed Quick Quality Clinic at North Pinellas, LLC Should the below named attorney cease representing Patient, this lien shall be binding on all subsequent lawyers or law-firms retained by Patient in this matter.

Attorney Name: _____
Attorney Phone: _____
Attorney's Signature: _____
Date: _____