Please tell us what you would like to be seen for today:

_____

PID:_____ VID: _____

Clinic use: _____

When did it start bothering you? _____ (date of onset)

Were you injured? ❍No ❍Yes ⇨ ❍At work ❍Auto accident ❍At home ❍Other_____

Next, review the symptoms below and mark the circle(s) next to any symptoms **related to your visit today**.

If an area is normal, or not related to today's visit, do not mark that circle.

GENERAL
- ❍ Pain _____ (location)
- ❍ Fever ❍ Chills
- ❍ Fatigue
- ❍ Weakness
- ❍ Unusual weight changes

EYES
- ❍ Something in eye
- ❍ **Vision problem** (blurry, loss of sight)
- ❍ Dryness ❍ Scratchy sensation
- ❍ Redness
- ❍ Excessive tearing
- ❍ Wear glasses / contacts

EARS
- ❍ Ringing in ears
- ❍ Hearing loss

NOSE
- ❍ Nosebleed
- ❍ Sinus Pain
- ❍ Runny nose

MOUTH, THROAT
- ❍ Growth in mouth ❍ White spots
- ❍ Tongue pain
- ❍ Toothache
- ❍ Soreness ❍ Trouble swallowing
- ❍ Swelling
- ❍ Hoarseness

HEART & CIRCULATION
- ❍ **Chest pain** ❍ Tightness ❍ Pressure
- ❍ Faintness ❍ Lightheaded
- ❍ Fast heartbeat ❍ Slow heartbeat ❍ Palpitations

LUNGS
- ❍ **Shortness of breath**
- ❍ Cough ❍ Wheezing
- ❍ Snoring ❍ Apnea

STOMACH, INTESTINES
- ❍ Nausea ❍ Vomiting ❍ **Rectal Bleeding**
- ❍ Indigestion ❍ Food intolerance ❍ Cramping
- ❍ Diarrhea ❍ Constipation ❍ Bloating ❍ Gas

***Clinic Use Only**: Provider Name:* _____

***Clinic Use Only**: Provider Signature:* _____

***Clinic Use Only:** Date:* _____

GENITAL
- ❍ Sores ❍ Discharge ❍ Bleeding ❍ Pain
- ❍ Swelling ❍ Abnormal Period Last Period: _____

URINARY
- ❍ Frequent urinating ❍ Painful urinating
- ❍ Losing control of urine/wetting self
- ❍ Blood in urine (discolored urine)

MUSCLES, JOINTS & BONES
- ❍ Joint stiffness ❍ Pain _____(location)
- ❍ Muscle pain ❍ Cramps _____(location)

SKIN
- ❍ **Wound**/Sore _____ (location)
- ❍ Rash _____(location)
- ❍ Dryness ❍ Itchiness

BLOOD/LYMPH
- ❍ Easy bruising ❍ Easy bleeding

ALLERGIES
- ❍ Seasonal Allergies ❍ Hives ❍ Welts
- ❍ **Other**: _____

NERVOUS SYSTEM
- ❍ **Recent head injury** ❍ Dizziness/Vertigo
- ❍ Speech problems ❍ Memory loss
- ❍ Fainting ❍ **Blacking out**
- ❍ **Seizures** ❍ **Sudden Paralysis**
- ❍ Headaches
- ❍ Poor balance ❍ Loss of coordination
- ❍ **Tingling** ❍ Numbness ❍ Weakness

PSYCHOLOGICAL
- ❍ Depression ❍ Loss of interest
- ❍ Nervousness ❍ Anxiety

HORMONES
- ❍ Heat intolerance ❍ Cold intolerance
- ❍ Night sweats
- ❍ Increased thirst ❍ Hunger

Patient Name: _____

Patient Signature: _____

Patient Date of Birth: _____

Primary Care Provider: _____

Today's Date: _____ (date of visit)

Patient's Additional History

ALLERGIES ❍ None ❍ I am allergic to latex ❍ I am allergic to band-aids

❍Yes, medication allergies: _____

❍Yes, other allergies: _____

CURRENT MEDICATIONS (include birth control, vitamins, supplements, herbals, over the counter & prescriptions)

Medication Name & Dose	Medication Name & Dose	Preferred Pharmacy
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	
_____	_____	

Past Medical History (ex. cancer, diabetes, high blood pressure, depression, surgery) ❍ Nothing new since last visit.

Medical Conditions: _____ ❍ None

Surgeries: _____ ❍ None

Major Accidents: _____ ❍ None

Other: _____

FAMILY HISTORY Please list any diseases that your immediate family have. List relative and disease. ❍ No changes since last visit.

Relative: _____ Disease(s): _____

Relative: _____ Disease(s): _____

Relative: _____ Disease(s): _____

❍ None ❍ Adopted

Is there a chance you are pregnant? ❍ Yes ❍ No **Do you have a pacemaker?** ❍ Yes ❍ No

SOCIAL HISTORY ❍Please check here if nothing below has changed since your last visit. You do not need to then re-complete this section.

TOBACCO USE ❍Never Smoked ❍Smoker in home ❍Smokeless Tobacco/e-cigarettes

❍ Current Smoker ___ packs/day for___ years ❍ Former Smoker ___ packs/day for __ years

DRUG USE ❍ Never Used

❍ Current User ❍Methamphetamines ❍Marijuana ❍Cocaine ❍Heroin ❍Steroids ❍PCP ❍Acid ❍Inhalants
amount _____ for _____ years

❍ Former User ❍Methamphetamines ❍Marijuana ❍Cocaine ❍Heroin ❍Steroids ❍PCP ❍Acid ❍Inhalants
amount _____ for _____ years

ALCOHOL USE ❍ Never Used

❍Current Drinker ____ drinks/day/week/month for ___ years ❍Former Drinker ____ drinks/day/week/month for ___ years

EXERCISE ❍Do not exercise

❍ Exercise regularly _____ minutes/day for ____ days/wk

CAFFEINE ❍ Do not drink caffeinated beverages

❍ Current caffeine _____ drinks/day for _____ years

Clinic Staff Use Only: _____

Patient Name:_____ Patient Date of Birth:_____

Please ***initial and sign*** to **select** your current **method of coverage**, and to complete the acknowledgement and consent for Medical Treatment, Notice of Privacy Practices, and Payment Policy.

___Self-Pay (FFS) Patient Visit

By signing below, I acknowledge that I have been informed of my responsibility to pay for the professional services or supplies provided to me today by DRX WA Urgent Care Providers PLLC, dba "Immediate Clinic".
I understand that these costs must be paid prior to the provision of such services through its authorized representatives.
I acknowledge and fully understand that the service(s) requested today will not be billed to any insurance carrier(s) at my request. I also understand that today's service(s) will be provided at a discounted rate and waive any right that I may have to require Immediate Clinic to attempt to bill any insurance carrier for these services. I further acknowledge that if I choose to submit an itemized receipt to any insurance carrier(s) for evaluation of partial or full reimbursement for these services that Immediate Clinic is exempt from any subsequent dispute regarding reimbursement but retains the option to submit these services for payment under the non-discounted insurance rates and guidelines upon mutual agreement by both parties when appropriate insurance information has been provided to Immediate Clinic.

___Health Insured Patient Visit

I request that payment of authorized insurance benefits, including Medicare, be made on my behalf for any professional services or supplies provided to me by DRX WA Urgent Care Providers PLLC, dba "Immediate Clinic".
I acknowledge that I have provided my insurance information today and authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related professional services or supplies by Immediate Clinic to the Health Care Financing Administration, my insurance company or other entity upon request to secure payment of my benefits.
I understand that I am financially responsible to Immediate Clinic for any charges not covered by health care benefits. It is my responsibility to notify Immediate Clinic of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I understand that I am responsible for the entire bill including any unpaid balance of the professional services or supplies as determined by Immediate Clinic and/or my health care insurer should the submitted claim or any part of the claim be denied for payment or apply to my co-pay, deductible or coverage limitations.

___CONSENT TO MEDICAL TREATMENT

I voluntarily present for treatment and consent to my Immediate Clinic provider to provide my care. Such care may include, but is not limited to, diagnostic procedures, x-rays, blood draws, laboratory tests, medication administration, and other procedures considered advisable in my diagnosis, treatment and course of care.
I acknowledge that my treatment is intended to address specific, episodic illnesses or injuries and is not intended as a substitute for a primary care physician or other specialized physician and that no guarantee can be made or has been made as to the results of treatments or examinations at Immediate Clinic.

___NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge review of Immediate Clinic's Notice of Privacy Practices, with a copy available upon request, as required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

___OFFICE POLICY ON PAYMENT

It is our policy to require all co-payments to be made at the time of service. All accounts over 60 days, after processed by the provided insurance, will be charged an interest rate of 2% a month or a $2.00 minimum. In the event any balance is not paid as agreed, the undersigned agrees to pay all costs charged by the Collection Company and reasonable attorney fee.
I understand that by signing this form I am accepting full financial responsibility as explained above for all professional services and supplies received. I understand this original authorization will be kept on file by Immediate Clinic and does not expire unless written notice is provided by me.

Name of person signing below (print):

_____

Signature of Patient or Guardian:

_____

Today's (Visit) Date:

_____

Relationship to Insured:
☐Self ☐Spouse ☐Dependent ☐Other

Relationship to Patient:
☐Self ☐Spouse ☐Guardian ☐Other

Visit Follow-up Communication

TEXT MESSAGE AND INFORMED CONSENT: In order to enhance patients' care and experience Immediate Clinic may contact you after your visit in order to request feedback on your experience by phone call, SMS text message, e-mail, voicemail, or mobile application, some of which may be via automated means. By signing below you understand and agree to be contacted in this manner with communications related to this visit, and any future visits.

In the future, you may opt-out of receiving text messages by notifying us in writing (including responding via text message). Standard telephone minute and text charges may apply if we contact you.

MOBILE SAFETY TIPS: While we work hard to protect your information, remember that electronic communication is never 100% secure. It's very unlikely, but information you send via text, email or mobile application, or that you leave on your mobile device, could be exposed to people other than your Doctor. Here are a few safety tips to follow:

(1) Use a password on your mobile device to prevent strangers from seeing what is on your phone.

(2) Limit the amount of sensitive health information you send. You can always call your provider to discuss something private or sensitive.

(3) If you are worried about those close to you seeing your messages, you can delete them from your email or messaging app. This won't erase them completely, but will make it hard for others to see them.

Patient Signature: _____

Date: _____