New Patient Urgent Care Form

DO YOU NOT have your insurance or ID Card?
Email it to us INFO@MSUC-ELKO.ORG

Patient Name: _____
Sex: ☐ Male ☐ Female ☐ Other Date of Birth: ____ / ____ / _____
Mailing/Physical Address: _____
City: _____ State: _____ Zip Code: _____
Email Address: _____
Phone Number: _____
Primary Care Provider: _____
Last Visit: ____ / ____ / _____
Race: ☐ White ☐ Black/African American ☐ Native/Hawaiian ☐ Asian
Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Other
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow
Preferred Language: ☐ English ☐ Spanish ☐ Other
Emergency Contact Name: _____
Relationship to Patient: _____
Emergency Contact Phone: _____

Pharmacy: ☐ Albertsons ☐Independence Drug ☐ Smiths ☐ Walmart ☐ CVS ☐ Golden Health
Preferred Lab: ☐ LabCorp ☐ Quest Diagnostics ☐ NNRH
Preferred Imagining Facility: ☐ HDI ☐ NNRH

Reason for Today's Visit:
_____
Duration of the symptoms: _____
Symptoms (check all that apply): ☐ Fever ☐ Chills ☐ Cough ☐ Shortness of Breath ☐ Chest Pain ☐ Nausea/Vomiting ☐ Diarrhea ☐ Abdominal Pain ☐ Headache ☐ Sore Throat ☐ Rash ☐ Injury ☐ Other _____
Pain Level (0-10): _____

Allergies

☐ No Known Allergies

Allergy	Allergic Reaction

Medications

Medications (list all)	Dose	Times Per Day

Health Maintenance Screening Test History

Cholesterol	Date:	Abnormal ☐ Y ☐ N
Colonoscopy	Date:	Abnormal ☐ Y ☐ N
Mammogram	Date:	Abnormal ☐ Y ☐ N
PAP Smear	Date:	Abnormal ☐ Y ☐ N
Bone Density	Date:	Abnormal ☐ Y ☐ N
PSA	Date:	Abnormal ☐ Y ☐ N

Surgeries

Type	Date	Location/Facility

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Personal Medical History

Disease/Condition	Current	Past
Alcoholism/Drug Abuse		
Asthma		
Cancer (type: _____)		
Depression/Anxiety/Bipolar/Suicidal		
Diabetes (type: _____)		
Emphysema (COPD)		
Heart Disease		
High Blood Pressure		
High Cholesterol		

Other Health Issues

Tobacco Use: Smoke Cigarettes/Vape ☐ Y ☐ N
Alcohol/Drug Use ☐ Y ☐ N
Other Tobacco ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew
Do you drink alcohol? ☐ Y ☐ N ☐ Beer ☐ Wine ☐ Liquor
How much Drinks/week: _____
Do you use marijuana or recreational drugs? ☐ Y ☐ N
Have you ever taken someone else's drugs? ☐ Y ☐ N
Sexually involved currently? ☐ Y ☐ N
Do you exercise regularly? ☐ Y ☐ N
How many hours on average do you sleep at night? _____
How would you rate your diet? ☐ Good ☐ Fair ☐ Poor

Insurance Information (If applicable).

Primary Insurance Company: _____
Policy Number: _____
Group Number: _____
Primary Subscriber Name: _____
Primary Subscriber Date of Birth: ____ / ____ / _____

HIPPA PRIVACY PROTECTION

Morning Star Urgent Care follows all federal HIPAA laws to protect your health information. Your medical records may be used or shared only for:

- ***Treatment***
- ***Billing and insurance***
- ***Healthcare operations***
- ***Situations required by law (public health, reporting, court orders)***

You have the right to:

- ***Request a copy of your records***
- ***Request limits on how your information is shared***
- ***Receive a full Notice of Privacy Practices***

Consent for Treatment

I hereby authorize the healthcare providers at Morning Star Urgent Care to provide medical treatment as deemed necessary and appropriate. I understand that I have the right to refuse any procedure or treatment.

Privacy Policy Acknowledgment and HIPAA Compliance

I acknowledge that I have received and read the privacy policy of Morning Star Urgent Care, which outlines how my personal health information will be used and safeguarded, in compliance with the Health Insurance Portability and Accountability Act (HIPAA).

Signature: _____ Date: _____


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