

BAY WALK-IN CLINIC, INC
PATIENT REGISTRATION FORM

Revised 01/08/08

Patient Information

Patient Name _____ Sex _____ Age _____
Date of Birth (month _____ day _____ year _____) Social Security Number _____
Home Address _____
City _____ State _____ Zip _____
Marital Status **M-S-D-W** (circle one) Home Phone _____ Cell Phone _____
Employer _____ Employer Phone _____
Employer Address _____
Local Contact _____ Local Phone _____

Spouse/Parent/Guardian Information

Name _____ Relationship to patient _____
Address _____
City _____ State _____ Zip _____
Phone _____ Social Security Number _____
Employer _____ Employer Phone _____
Employer Address _____

Insurance Information

Primary Insurance _____ Phone _____
Address _____
Policy Number _____ Group Number _____
Insured Name _____ Relationship to Patient _____
Insured Employer _____ Employer Phone _____
Employer Address _____
Insured Date of Birth month _____ date _____ year _____ Social Security Number _____

Secondary Insurance _____ Phone _____
Address _____
Policy Number _____ Group Number _____
Insured Name _____ Relationship to Patient _____
Insured Employer _____ Employer Phone _____
Employer Address _____
Insured Date of Birth month _____ date _____ year _____ Social Security Number _____

I hereby agree the above information is true and accurate to the best of my knowledge.

Patient/Guardian Signature _____ Date _____

Witness Signature _____ Date _____

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Patient Registration

Emergency Contact

Name _____ Relationship to patient _____
Address _____ City _____ State/Zip _____
Home Phone _____ Cell Phone _____

Consent to Treat

I hereby give my permission and consent for Bay Walk In Clinic, Inc. and staff to treat me using generally accepted standards of medical care. I am aware that medicine and surgery are not exact sciences and no guarantee for successful outcome has been made or implied to me. I understand that treatment for my condition(s) will be based upon the information that I provide. I accept full responsibility should I provide inaccurate, incomplete, or misleading information. I certify that the identifying information, address, and telephone information is correct and agree to provide Bay Walk-In Clinic, Inc. and staff if such information changes or becomes outdated. I understand that Bay Walk-In Clinic, Inc. and staff can not contact me if I have provided incorrect or illegible information or should I not keep this information current and correct.

Patient *PRINTED* Name

Patient Signature

Date

Witness

Date

Authorization to Release Information

I hereby authorize Bay Walk-In Clinic, Inc. the release of medical or personal identifying information including HIV results, substance of abuse, and or mental health records to any health insurance company, workers compensation carrier, and/or employer, providing evidence, for the purpose of payment of your claim. I also authorize the release of my medical record or communication of pertinent information from Bay Walk-In Clinic, Inc. to any agency or provider I have been referred. I also authorize any medical organization to release medical information to Bay Walk-In Clinic, Inc. for the purpose of treatment or payment.

Assignment of Benefits

I hereby irrevocable directly assign any insurance benefits for my treatment and bill to Bay Walk-In Clinic, Inc.

Payment of Services

All patients are financially responsible for all services rendered at Bay Walk-In Clinic, Inc. Patients with no insurance are to pay in full at time of service. Insurances must be verified and approved prior to acceptance, although this in **NOT** a guarantee of payment from your insurance company. **Office visits, Co-pays, deductibles, and other services not covered by your insurance are to be paid in full at time of service.** You will be billed separately for x-ray interpretation and certain lab test. **You the patient remain responsible for payment for services if your insurance company has not paid your claim within 45 days. Payment may be automatically processed with the method of payment listed on file.** This practice does use legal means provided by law to collect bad dept accounts and returned checks. Returned checks may be directly withdrawn from your account with a fee applied.

Today's payment will be made by: Cash _____ Check _____ Credit Card Visa _____ MasterCard _____ American Express _____
Number _____ Exp _____

I hereby have read the above information and agree to the terms therein.

Patient *PRINTED* Name

Patient Signature

Date

Witness Signature

Date

HEALTH HISTORY INFORMATION SHEET

Patient Name _____ Age _____

Today's Medical Complaint _____

Is this due to an injury? _____ Date of injury _____ Place of injury _____

Brief description of how injury occurred _____

Current Occupation _____

Do you have any allergies? _____

Are you allergic to latex? _____

Have you ever been treated or diagnosed with any of the following?

Frequent Headaches	yes	no	Diabetes or thyroid problems	yes	no
Bowel/Bladder Problems	yes	no	Cancer	yes	no
Hypertension	yes	no	Broken Bone/Sprains	yes	no
Arthritis	yes	no	Back Problems	yes	no
Skin Conditions	yes	no	Stomach Problems	yes	no
Psychiatric Problems	yes	no	Kidney Problems	yes	no

Describe any treatment of the above problems _____

Current or Past Medical Illness or Disease _____

Past Surgeries _____

List current prescription and non-prescription medication you are taking.

Do you have a living will or advance directive? _____

Do you have a family physician? _____

Family physician name _____

Are you up to date on your immunizations? _____

Date of last tetanus _____ Pneumonia Vaccine _____

Influenza Vaccine _____ Hepatitis Vaccine _____

Date of your last physical exam _____

I hereby agree the above past and current medical information is true and accurate to the best of my knowledge.

Patient Signature Date

Witness Signature Date

