HH Walk-in Clinic

Chart: ____

NEW PATIENT FORM

HH Walk-In Clinic is an urgent care clinic, NOT an emergency room. Patients with emergent needs should proceed IMMEDIATELY to the Emergency Department.

Not all insurances and conditions are appropriate at this facility, please see the placard for a list of conditions we cannot treat. The receptionist will inform you and assist you in finding appropriate care should your condition/ insurance not be appropriate.

Today's Date: ____________ Patient Name: ____________________________________

Date of Birth: ____________ Social Security Number: ____________________ Martial Status: M S D W

Gender: Male or Female Employer: ____

Mailing Address: ____

City: ______________________ State: __________ Zip Code: ____________

Cell Phone: ______________ Home Phone: ______________ Work Phone: ______________

Preferred Contact Method: Cell Home Work Email: ______________________________

Emergency Contact #: ______________ Name: __________________ Relation: ______________

Insurance: YES or NO *(COPAYS ARE REQUIRED AT CHECK-IN)*
If you DO NOT have insurance and you are a new patient, a minimum fee of $114.40 will be due. If you DO NOT have insurance and are a returning patient, a minimum fee of $75.25 will be due. Your visit may result in a charge in excess of this amount.

	Insurance Type	Card Holder Relation	Date of Birth
1.			
2.			
3.			

MEDICARE PATIENTS ONLY ....

Medicare Secondary Payer

Part I

— Are you receiving Black Lung Benefits? Yes No
— Are the services to be paid related to government research programs? Yes No
— Has the Dept. of Veteran Affairs authorized and agreed to pay for care at this facility? Yes No
— Was the illness or injury due to work related accident/condition? Yes No

Part II

— Was the illness/injury due to a non-work related accident? Yes No

Part III

— Are you entitled to Medicare based on age-65 and over? Yes No
If no, please inform receptionist for full MSP form to complete

Part IV

— Are you currently employed? Yes No
— Is you spouse currently employed? Yes No

HH Walk-in Clinic

Chart: ____

Date: ____________________

Name: ____________________ Date of birth: ____________________

Reason for visit: ____________________

(It is policy to only see ONE major complaint per visit, additional complaints may be addressed at provider's discretion)

How long have you had your symptoms: ____________ day(s) month(s)

PAST/PRESENT MEDICAL HISTORY *(Please check if you have any of the below.)*

- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Anemia
- ☐ Anxiety
- ☐ Autoimmune Disease (Lupus)
- ☐ Biliary Cirrhosis
- ☐ Blood Transfusion
- ☐ Brain Tumor
- ☐ Cerebrovascular Disease
- ☐ Cirrhosis
- ☐ CVA/Stroke
- ☐ COPD (Lung Disease)
- ☐ Colon Cancer
- ☐ Coronary Heart Disease
- ☐ Crohn's Disease
- ☐ Chronic Renal Failure
- ☐ Depression
- ☐ Diabetes - Juvenile Onset
- ☐ Diabetes - Adult Onset
- ☐ Diverticulitis
- ☐ DVT (Blood Clot in Legs)
- ☐ GI Bleed
- ☐ Gerd (Acid Reflux)
- ☐ Hemochromatosis
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Infertility
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ MI (Heart Attack)
- ☐ Neurologic Disorder
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ PVD
- ☐ PUD (Stomach Ulcers)
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Valvular Heart Disease
- ☐ UTI - Recurrent
- ☐ Varicose Veins/Phlebitis
- ☐ Abnormal Pap Smear
- ☐ Breast Disease
- ☐ Breast Cancer
- ☐ Cervical Cancer
- ☐ Des Exposure
- ☐ Gestational Diabetes
- ☐ Rh Sensitized
- ☐ Sleep Apnea

Using CPAP? Yes / No

Other____________________

PAST SURGICAL HISTORY

- ☐ ABD Surgery
- ☐ Amputation
- ☐ AV Fistula Creation
- ☐ AV Graft
- ☐ Aortic Valve Replacement
- ☐ Aortic Valve Replaced
- ☐ Appendectomy
- ☐ Both Legs Bypassed
- ☐ Back Surgery
- ☐ Mastectomy Right / Left
- ☐ Breast Augmentation
- ☐ Bronchoscopy (Lung Scope)
- ☐ CABG (Heart Bypass)
- ☐ Carotid Endarterectmy
- ☐ Carpal Tunnel
- ☐ Cataract Extraction
- ☐ Gallbladder Removed
- ☐ Colon Resection
- ☐ Craniotomy
- ☐ Gastric Bypass
- ☐ Hemorrhoidectomy
- ☐ Hip Replacement
- ☐ Invasive Pain Procedure
- ☐ Knee Arthroscopy
- ☐ Knee Replacement
- ☐ Kyphoplasty
- ☐ Lumpectomy Right / Left
- ☐ Mitral Valve Replaced
- ☐ Nephrectomy
- ☐ Kidney Transplant
- ☐ Pacemaker Implanted
- ☐ Parathyroidectomy
- ☐ Pneumonectomy
- ☐ PTCA (Angioplasty)
- ☐ Rotator Cuff Repair
- ☐ Tonsil's Removed
- ☐ Thyroid Surgery
- ☐ Vascular Surgery
- ☐ Prostate Surgery
- ☐ Shoulder Surgery
- ☐ Sleep Apnea Surgery
- ☐ ABD. Hysterectomy
- ☐ Hysterectomy/Ovaries
- ☐ Ovaries Removed Yes / No

Other____________________

Walk-in Clinic

Chart: ____

FAMILY HISTORY *(Check appropriate)*

	Father	Mother	Brother	Sister	Children
Arthritis	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Heart Artery Disease/Heart Attack	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Kidney Disease (Chronic)	☐	☐	☐	☐	☐
Thyroid Disorder	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐

SOCIAL HISTORY *(Check or circle appropriate)*

☐ Married ☐ Single ☐ Divorced ☐ Widowed

Work ☐ Part-Time ☐ Full-Time ☐ Retired ☐ Disabled Occupation:____________________

Children: Yes / No Religious Affiliation ____________________

RISK FACTORS *(Check or circle appropriate)*

☐ Current tobacco use Year started: ________

Type of tobacco: Cigarettes / Cigars / Smokeless

☐ Former tobacco use: Year quit: ________

☐ Never smoked

☐ Second hand smoke

☐ Caffeine use How many drink per day: ____

☐ Alcohol use How many drink per day: ____

Type: ____________

☐ Exercise Times per week: ________

Type: ____________

ALLERGIES OR MEDICATION REACTIONS ☐ **NO KNOWN DRUG ALLERGIES**

Allergic to: Reaction:

____

____

____

CURRENT MEDICATIONS ☐ **REFER TO LIST** ☐ **REFER TO BOTTLES** ☐ **NO MEDICATIONS**

Please include the dose and how often you take the medication.

(No need to list below if you brought a list or bottles)

Name	Dosage	How many times per day?	As Needed (PRN)

Pharmacy Name ______________________________ Phone # ____________________

Location ______________________________

Walk-in Clinic

Chart: ____________

Primary Care Doctor: ______________________________

Pain: Yes No Location: ______________ Description: ______________ Intensity (1-10): ______

Patient/Guardian consent to receive medication history on patient via electronic prescription: Yes No

Signature of patient/guardian: ______________________________

Date: ______________

Please enter the most recent date and results of the following:

	Date	**Results**	**Performed by (who/where)**
Colonoscopy			
Pap Smear			
Mammogram			
Bone Density Scan			
Menstural Period			
PSA (Prostate Sceen)			

When was your last vaccine on the following:

	Date	**Would you like one?**
Flu Vaccine		Yes / No
Tetanus Vaccine		Yes / No
Pneumonia Vaccine		Yes / No
Shingles Vaccine		Yes / No