APPALACHIAN
Regional Medical Associates
A Division of Appalachian Regional Healthcare System
App Urgent Care

Patient Name_____
Date of Birth_____
Phone Number_____
Please Fill in or Affix a Patient Label

Patient Registration

Please Print Patient Name: First M/I Last

Gender: ☐Male ☐ Female **Date of Birth:** ____/____/_____ **Social Security #:** _____-_____-_____

Mailing Address: Street-

City- State- Zip Code-

Home Phone #: _____ **Work Phone #:** _____

Cell #: _____ **E-mail:** _____

Employer/Occupation: _____

Marital Status: ☐Married ☐Single ☐Divorced ☐ Separated ☐Widowed ☐ Partner

How did you hear about us?
☐ Billboards ☐Doctor ☐Friends/Family ☐Magazine ☐Newspaper ☐Social Media ☐Radio ☐TV
☐ARHS Website ☐Other _____

What is your ethnicity? ☐Hispanic or Latino ☐ Not Hispanic or Latino

Select one or more races to indicate what you consider yourself to be: ☐Asian ☐ White
☐ American Indian or Alaskan Native ☐ Black or African American
☐Native Hawaiian or other Pacific Islander ☐ Other: _____

Preferred language? ☐English ☐Other: _____

Which Pharmacy do you use: _____

Emergency Contact Name and Relationship: _____
Emergency Contact Number: _____

If patient is a minor:
Please Print Guardian Name: First M/I Last

If someone else is responsible for the bill:
Patient's relationship to Guarantor: _____
Guarantor's Name: First M/I Last

Mailing Address: Street-

City- State- Zip Code-

Date of Birth: ____/____/_____ **Social Security #:** _____-_____-_____ **Phone #:** _____

Employer: **Employer Phone#:**

Referring Doctor: _____ **Primary Care Provider:** _____

Effective Date: 03/01/2012
Revised Date: 10/23/2012
Form Number: 10649

APPALACHIAN
Regional Medical Associates
A Division of Appalachian Regional Healthcare System
Appalachian Urgent Care Center

Patient Name_____
Date of Birth_____
Phone Number_____
Please Fill in or Affix a Patient Label

Medical History Form

Date: _____ Family Doctor/Primary Care Provider: _____ ☐ None ☐ Out of town

Reason for Today's visit: _____

_____

Pharmacy of choice: _____

Allergies: ☐ No Known Drug Allergies ☐ No Known Latex Allergies

Medication/Environmental Allergy	Reaction/Side Effect
☐ LATEX ALLERGY	

Current Medication: ☐ None ☐ See attached list

Medication	Dose	Frequency

Medication	Dose	Frequency

Past Medical History: ☐ None

☐ Asthma
☐ Atrial Fibrillation
☐ Anxiety
☐ Arthritis
☐ Cancer: _____
☐ Coronary Heart Disease
☐ CVA/Stroke
☐ COPD
☐ Depression
☐ Diabetes:
☐ Type I ☐ Type II
☐ DVT
☐ Fibromyalgia
☐ GERD
☐ High Blood Pressure
☐ High Cholesterol
☐ Hyperthyroid
☐ Hypothyroid
☐ Kidney disease
☐ Kidney stones
☐ Liver disease
☐ Seizures
☐ Other: _____
_____
_____

Past Surgical History: ☐ None

☐ Appendectomy
☐ Heart Surgery/CABG
☐ Back Surgery
☐ C-section
☐ Defibrillator implant
☐ Gall Bladder Surgery
☐ Gastric Bypass
☐ Hemorrhoidectomy
☐ Hip Surgery
☐ Hysterectomy
☐ Knee Surgery
☐ Lumpectomy
☐ Mastectomy
☐ Pacemaker implant
☐ Shoulder Surgery
☐ Tonsillectomy
Other: _____
_____
_____
_____

Social History/Risk Factors:

Marital status: ☐ Single ☐ Divorced ☐ Married ☐ Widowed Lives: ☐ Alone ☐ w/spouse/partner/parent(s) ☐ w/children
Minor Children: ☐ Lives with both parents ☐ Lives with ☐ mother ☐ father ☐ Other: _____
Occupation: _____ Education Level: _____
Tobacco Use: ☐ Never Smoked ☐ Current Smoker: _____ packs/day ☐ Former Smoker: (year quit) _____
Alcohol Use: ☐ No ☐ Yes: Type _____ Number of drinks per day: _____
Recreational Drug Use: ☐ No ☐ Yes: Substance _____
Female History: First day of last menstrual period: _____ Pregnant: ☐ No ☐ Yes ☐ Unknown/Possibly
Immunization Status: ☐ Up to date for age ☐ Not up to day ☐ Unknown
List year of last vaccine: Tetanus: _____ Influenza: _____ Pneumococcal: _____

☐ Staff Reviewed: _____ Date: _____ Time: _____

Effective Date: 09/10/2012
Revised Date: 04/12/2016
Form Number: 10499

APPALACHIAN
Regional Medical Associates
A Division of Appalachian Regional Healthcare System
at App Urgent Care

Patient Name_____
Date of Birth_____
Phone Number_____
Please Fill in or Affix a Patient Label

Authorization of Release and Consent

Name: _____ **Date:** ___/____/____

Release of Medical and/or Financial Information: Persons authorized to receive information

Name: _____ Relationship:_____ Phone: _____
☐Medical (i.e. results of lab tests/ x-rays) ☐Appointment information ☐Financial ☐Other

Name: _____ Relationship:_____ Phone: _____
☐Medical (i.e. results of lab tests/ x-rays) ☐Appointment information ☐Financial ☐Other

Name: _____ Relationship:_____ Phone: _____
☐Medical (i.e. results of lab tests/ x-rays) ☐Appointment information ☐Financial ☐Other

Initial

Consent to Receive Communication on Cell Phone

_____ ☐ I do hereby authorize ARHS and its subsidiaries to call my cell phone to communicate with me or to leave a message for me for financial reasons such as balance due, new insurance and financial assistance as well as appointments, wellness checkups, pre-registration, lab results, and any other healthcare related information.

My cell phone number is: _____

ARMA and its subsidiaries may also send me messages me via:
☐Email: _____ ☐Other: _____

Initial

Consent for Medical Treatment

_____ ☐ Knowing that I am seeking medical care/medical testing, I hereby voluntarily consent to such medical care encompassing diagnostic procedures and medical treatment by my physician, his/her assistants or his/her designees as may be necessary in his/her judgment. I am aware that the practice of medicine and surgery is not an exact science and I acknowledged that no guarantees have been made as to the results of treatments or examinations in the hospital/practice. This form has been fully explained to me and I certify that I understand its contents

Initial

Assignment of Insurance Benefits

_____ ☐ I hereby authorize direct payment of surgical and medical benefits to the physician or to whomever he/she designates and I also authorize direct payment of all other benefits to ARHS and its subsidiaries. The benefits referred to herein would be payable to me if I did not make assignment and include major medical insurance. I understand that I am personally responsible to practice and physician respectively for charges not covered by this agreement. I also authorize ARHS and my attending physician to release any medical information required in processing of applications for final coverage for services rendered.

Initial

Medicare-Medicaid Patient's Certification

_____ ☐ I do hereby authorize ARHS and its subsidiaries to release information and request payment. I certify that the information given by me in applying for payment under Titles XVIII and XIX of Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf.

Effective Date: 03/01/2012
Revised Date: 09/07/2016
Form Number: 10626

APPALACHIAN
Regional Medical Associates
A Division of Appalachian Regional Healthcare System
at App Urgent Care

Patient Name_____
Date of Birth_____
Phone Number_____
Please Fill in or Affix a Patient Label

Authorization of Release and Consent

Initial

3rd Party Billing Agreement

_____ ☐ I acknowledge and understand that in addition to a bill from Appalachian Regional Medical Associates, patients who accept the services for pathology, laboratory, or imaging will receive a separate bill from the respective service provider.

Initial

Notice of Privacy Practices and the Financial Information

_____ ☐ I have received and understand the notice of Privacy Practices and the Financial Information brochures.

Initial

_____ ☐By signing below, I hereby authorize Appalachian Regional Medical Associates to obtain the last 2 years of Medication History related to the patient above, from the community pharmacies and/or pharmacy benefit managers for the purpose of continuity of care.

I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations.
- The right to revoke this authorization at any time.

_____ _____
Signature of Patient *Date* *Time*

_____ _____
Signature of Guarantor *Date* *Time*

_____
Description of Personal Representative's Authority (attach necessary documentation)

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