Wyoming Urgent Care

Because illnesses don't happen by appointment

First Visit

DATE

What is your insurance?

Primary:

Secondary:

Who is the subscriber? :

What is the DOB of the subscriber? :

I am Vaccinated for Covid

Yes { } No { }

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FIRST VISIT

TODAY'S DATE: _____

PATIENT'S NAME: _____ **DOB:** _____ **Marital Status: S M W Dv Sp**

ADDRESS: _____ **Town, State** _____ **ZipCode** _____

PHONE: _____ **CELL PHONE:** _____ **SSN:** _____

EMAIL: _____ **EMPLOYER:** _____ **PHONE:** _____

PRIMARY PHYSICIAN _____ **PHONE:** _____

EMERGENCY CONTACT: _____ **PHONE:** _____

YOU WANT TO BE SEEN FOR? ----------

Allergy ----------

PRESENT ILLNESS:

- Did this Injury happen at work ☐Yes ☐No If yes, Date of Injury: _____
- Motor Vehicle Related? ☐Yes ☐No If yes, Date of accident: _____
- How long have you had this problem: _____
- Severity of your pain (Circle one): 1 2 3 4 5 6 7 8 9 10

GENERAL MEDICAL INFORMATION:

Are you pregnant? ☐Yes ☐No HEIGHT: _____ WEIGHT: _____

Please tell receptionist if you have any of the following: Abdominal pain Chest Pain Confusion Numbness of arm or leg sudden loss or change of vision

Please list medications you are currently taking: _____

_____

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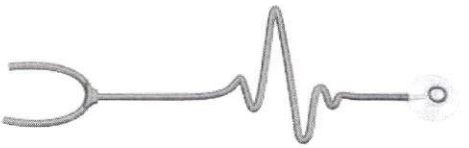

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CONSENT TO TREAT:

I hereby consent to medical evaluation, testing and/or treatment provided to me by the Wyoming Urgent Care staff. I understand that such medical care may include history taking, diagnostic testing and administration of medication and/or treatment. I understand I may discontinue treatment or any part thereof.

DISCLOSURE OF MY PROTECTED HEALTH INFORMATION:

I understand that Wyoming Urgent Care may use or disclose my Protected Health Information to carry out treatment, payment, or healthcare. Any information concerning mine (or my child's) health care, advice and treatment provided for the purpose of obtaining insurance benefits.

ASSIGNMENT OF BENEFITS:

I also hereby authorize payment of insurance benefits, otherwise payable to me be made directly to Wyoming Urgent Care. I understand I am responsible for any balance not paid by my insurance.

Signature of patient or responsible party _____ Date_____

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HIPAA form to be sign by patient

RIGHT TO RECEIVE NOTICE OF CHANGE TO DR. LESLY GERMAIN MDPC PRIVACY STATEMENT

You have the right to receive any changes to our privacy statement that affect you on or after the effective date of change. If you have any questions about this notice contact any of the contact persons listed below.

Dr. Lesly Germain MDPC

hereby acknowledge that I have received a copy of this practice's **NOTICE OF PRIVACY PRACTICES**. I understand that if I have questions or comments regarding my privacy rights that I may contact any of the persons listed above. I further understand that the practice will offer me updates to this **NOTICE OF PRIVACY PRACTICES** should it be amended, modified, changed in any way.

Please list the names of any persons to whom you wish us to disclose your PHI and state how the individual is related to the patient:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Other uses and disclosures require your written authorization

Signature: _____Date:_____

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SURGICAL/HOSPITAL HISTORY

What surgeries or hospitalizations have you had, and when?

_____

List any ongoing medical conditions: _____

_____

Alcohol Consumption: ☐Daily ☐Weekly ☐Monthly ☐Rarely ☐Never

Tobacco Use:
How much per day _____ when did you start: _____ Quit: ☐Yes ☐No when: _____

Illegal Drug Use: ☐Daily ☐Weekly ☐Monthly ☐Rarely ☐Never

FAMILY MEDICAL HISTORY:

_____

_____

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We are sorry to have to ask the following questions, they are required by the EMR.

Gender Identity

( ) Male
( ) Female
( ) Transgender Male/Trans Man/Female-to-Male
( ) Transgender Female/Trans Woman/Male-to-Female
( ) Genderqueer, neither exclusively Male nor Female
( ) Patient declines to specify

Sexual orientation

( ) Straight or heterosexual
( ) Lesbian, gay, or homosexual
( ) Bisexual
( ) Patient declines to specify

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MEDICAL DOCUMENTATION

Date:_____Time In:_____(am /pm) Time Out: _____(am /pm)
Patient Name:_____DOB:_____
Preferred Pharmacy: _____
PCP: _____

Height: _____ Weight: _____ Blood Pressure: _____/ _____
Temperature: _____ Pulse: _____Respiration: _____ P O2(1):_____
Allergies: _____
Current Medications: _____
_____

INSURANCE PLAN: _____

Subjective	**Conjunctivitis [ ] Sore Throat [ ] Asthma [ ]** **Laryngitis [ ] Nasal Congestion [ ] Earache [ ]** **Rhinorrhea [ ] Green [ ] Yellow [ ] Since_____** **Cough [ ] Since_____**
Objective	**Ears: Cerumen [ ] Redness [ ] Fluid presence [ ] Pain [ ]** **Throat ,: Tonsils present [ ] Inflammation [ ] Exudation [ ] Abscess [ ]** **Sinus: Tenderness [ ]** **Lymph Node: Enlargement [ ] Tenderness [ ]**
Assessment	**Diagnosis:** **Treatment:**

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DISCHARGE PLAN

Please give this to the PCP

You have been diagnosed with:

_____

You were prescribed the following medication(s):

_____

_____

_____.

_____

_____

_____.

.

Follow the above instructions carefully. Take your medications as prescribed. Most importantly follow up with you PCP. If you have any questions or concerns call or visit your PCP. If unable to reach your PCP or your condition gets worse, please return to Wyoming Urgent Care or your local Emergency Department for further evaluation. Do not hesitate to call us with any questions or concerns at the office or after hours at (585)322-6422.

I have received this information. The doctor has addressed any questions or concerns I have with my plan of treatment.

_____ _____

Signature of patient/Responsible person Dr. Germain