Westlake Village Urgent Care Occupational & Family Medical Clinic

Today's Date_____

Patient Information

Last Name_____ First Name_____ M_____

Date of Birth _____Gender M ___F___ Marital Status M___D___S___W__

SSN#_____-_____-_____ Driver's License State_____ Number_____

Home Phone#_____Cell#_____

Email Address_____

Address_____Apt#_____

City_____ State_____ Zip _____

Employer _____ Phone# _____

Information of responsible Party/Insured (if different from above)

Name _____ Relationship to Patient_____

Responsible Party SSN#_____-_____-_____ Date of Birth _____

Driver's License/State ID:_____ Home Phone# _____

Address _____ Apt# _____

City _____ State _____ Zip _____

Employer _____ Phone# _____

***Emergency Contact _____ Phone#_____

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For WVUC Office Use Only

Insurance Information (In Network) (HMO) (Out of the Network) (No Insurance)

Phone: (805)379-9125 * Fax: (805)379-2311

1220 La Venta Dr. Suite 101 * Westlake Village Ca. 91361

Westlake Village Urgent Care, Occupational and Family Medical Clinic
OFFICE POLICIES AND GENERAL CONSENT

Consent for Treatment

I hereby consent to and authorize administration of all diagnostic testing and treatment that may be considered advisable or necessary in the judgment of the attending physician of the Westlake Village Urgent Care. I recognize that medicine is not an exact science and that my diagnosis and treatment may involve risks. Furthermore, I acknowledge that no guarantees have been made to me as the result of examinations or treatments.

Personal Valuables

I understand and agree that the facility shall not be liable for the loss of or damage to any of my personal property.

Financial Agreement

I, the undersigned agree, whether I sign as the parent/agent/guardian or as the patient, that in consideration of the services to be rendered to the patient, I hereby obligate myself to pay the account of the facility in accordance with the regular rates and terms of the facility. Should the account be referred to collection, I the undersigned, shall pay actual collection expense. There will be an additional charge of $25.00 added to any "bounced"/returned check.

The Westlake Village Urgent Care will bill and or assist you in billing any third party payer. However, please understand that the balance in full is your responsibility. If your insurance carrier has not paid in thirty days, the balance will be turned to you/the patient and payment in full will be expected. It is the patient's responsibility to understand the extents and limitations of their own insurance policies.

All copays are due at the time of service. If we are an out of network provider or you do not have a third party payer, payment in full is expected at the time of service.

Assignment of Benefits: I, the undersigned, authorize, whether I sign as an agent or as the patient, direct payment to the facility of any insurance benefits otherwise payable to me for this office visit. I request payment of authorized benefits directly to Westlake Village Urgent Care for services furnished to me at this facility. I consent to the release of medical and other information related to such services for healthcare operations and to Medicare, my insurance company, HMO, other third party payers, or their third party administrators, in order to process and pay claims, determine benefits and perform quality of care reviews.

Medicare does not cover tetanus shots or any preventative care.

HIPPA Notice of Privacy Practices

I have been provided with the 2 page document titled *"HIPPA Notice of Privacy Practices"* and agree to those terms. I understand that I may request a hard copy of this document at any time.

Contact Mechanism

Urgent Care Staff may TEXT or leave a detailed voice message for me regarding Test Results, Follow-up, Billing etc at the following number and/ or email.

(_____) - _____ - _____ _____@_____

_____ _____/_____/_____

Patient Name- Please Print Date of Birth

_____ _____/_____/___2020____

Signature of patient or authorized representative Today's Date

WESTLAKE VILLAGE URGENT CARE HEALTH HISTORY FORM

Name: _____ **Age:** _____ **M / F Date:** _____/_____/_____

Why are you here today? (Please circle all that apply) or **Other (Please Explain):** _____

Pain: Chest Back Neck Abdomen Ribs Ear(s) Eye(s) Face Headache Bone Injury Other: _____

"Cold/Flu" Symptoms: Hard to Breathe Fever Chills Sore Throat Body Aches Runny Nose Sinus Congestion Cough Wheezing

GI/GU: Diarrhea Nausea Vomiting Constipation Heartburn Urinary Pain/Frequency (UTI) Gynecological Concern

Misc: Palpitations Swelling/Edema Dizziness Numbness Weakness Fatigue Anxiety Depression Insomnia Vision Change

Rash/Skin Problem Allergic Reaction Other: _____

Wellness Visit: Physical (Work/Sports) Labs/Shots/B-12 STD Screening TB Screening Elective Vitamin IV

Is this work related? (Please circle) **No** **Yes (Please Explain):** _____

Please circle all past medical history and LIST or attach MEDICATIONS or treatments *(example: Lipitor 10, diet control)*

Health History	*MEDICATIONS (Prescribed & Over-the-Counter)/Treatments*
High Blood Pressure / High Cholesterol	
Heart Disease / Blood Clots	
Kidney / Liver Disease	
Anxiety / Depression/Mania	
Asthma / COPD	
Diabetes / Thyroid Problems	
GI / GERD / Ulcers	
Injuries / Musculoskeletal	
Surgeries / Hospitalizations	
Other	

Please list any additional medical history concerns or treatments/medicines taken:

_____

_____

Allergies

List Drug Allergies: _____

List Environmental Allergies (Latex, Tape, Pollen, Etc.): _____

Social History

Tobacco/Nicotine Marijuana Use	No	**QUIT!!! (year)?** _____ **YES:** Smoking/Chewing/Vaping per day? _____ times, how many years? _____		
Alcohol Use	No	Yes: 1-5 per year _____ 1-5 per week _____ 1-2 per day _____ More than 2 per day _____		
Drug Use	No	Yes, please list:		
Exercise	No	Yes, please list how many days per week:	***Type of Work (circle)***	Indoor Outdoor Active Sedentary
Travel History/Exposures	International travel? (circle) No Yes, travel date:___/___/_____ Have you recently been exposed to someone ill? (circle) No Yes, date of exposure:___/___/_____			

Family History (Please circle all that apply)

Heart Disease Stroke Diabetes Kidney Disease Liver Disease Asthma Migraines Cancer Anxiety/Depression High Blood Pressure

Female History

Are you pregnant?(circle) Yes No	Last menstrual period? ___/___/___	Birth control used?
Date of last pap smear: ___/___/___	Do you have a history of abnormal pap smears? (circle) Yes No If yes, please give the date: ___/___/___	

Children's History

Are immunizations up to date?(circle) Yes No	Normal development?(circle) Yes No, explain:_____
Does anyone in the house smoke?(circle) Yes No	Animals in the house? No Yes, (Circle) Dog, Cat, Bird, Rodents, Reptiles

Patient Signature: X_____ **Reviewed by Provider:** X _____