Gardens
Urgent Care
Fast. Quality. Care.

3555 Northlake Blvd.
Palm Beach Gardens,
Florida 33403
(561) 626-4878
(561) 627-5112 | fax

7408 Lake Worth Rd.
Lake Worth, FL 33467
(561) 721-7227
(561) 721-7228 | fax
www.gardensurgentcare.com

Gardens Urgent Care Rapid Registration Pack

1. Fill out all 3 forms. If you have any questions or have difficulty, call or come in and we can assist you with this.

2. If you have insurance coverage, bring your insurance card and a picture ID. If you are not the primary policy holder, please provide the policy holder's name and birthday on the forms.

3. Bring in a form of payment (cash/credit card). We do not accept checks.

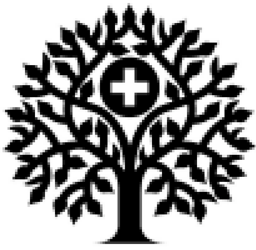
4. Call ahead if you need special assistance (like help getting out of your car if you are hurt or assistance with a bleeding wound, etc.). We can be ready to assist you when you arrive.

5. Come in and see us.

Palm Beach Gardens: 561-626-4878
3555 Northlake Boulevard,
East of I-95 on the North side of the street.
Across from Checkers, next to Suntrust Bank.

Lake Worth: 561-721-7227
7408 Lake Worth Road
East of the turnpike, near the corner of Lake Worth Rd and Ohio Road
At the Market Place Plaza in the Lake Worth Medical Center Building

Call for assistance or more detailed directions.



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PATIENT DEMOGRAPHICS

Welcome to Gardens Urgent Care Please Print

Patient Name: ____________________ , ____________________ ________
Last First MI

Parents/Guardian Name if Minor: ____________________ ____________________
Last First

DOB: ______/______/________ Age: ________ Sex: ☐Male ☐Female

Patient's SSN: ________- ________-__________ Primary Language: ____________________

Race: ____________________ Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Decline

Address: ____

City: ____________________ State: ____________ Zip Code: ______________

Preferred Communications: ☐ Mail ☐ E-Mail ☐Phone ☐ Text ☐Fax ☐Other: ____________________

Home Phone: (_____) ______-_______ Work Phone: (_____) ______-_______ Cell Phone: (_____) _______-__________

Emergency Contact: ____________________ ______________ (______) ________-___________
Name Relationship Phone Number

☐Married ☐Single ☐Other: ______________ E-Mail Address: ____________________

If not local, specify other address: ____

Do You Have Insurance? ☐ Yes ☐No Insurance Company: ____________________

Insurance Policy #: ____________________ Group #: ____________________

If you are not the main policy holder on the insurance card, please provide the following information:

Name of Policy Holder: ____________________Policy Holder DOB: ______/_____/_______

Relationship to the Patient: ☐Spouse ☐Parent ☐Other: ____________________

If this is a Workers' Compensation case, please fill out this portion: Claim #: ____________________

Name of Business: ____

Manager: ____________________ Phone: (_____) _______-_________

Address: ____

City ____________________ State: ______________ Zip Code: ______________

How did you hear about us? ☐Drove by the sign ☐Other: ____________________
Internet: ☐Yellowpages.com ☐Google ☐Yahoo ☐Other:____________________
Phone Book: ☐Bellsouth Yellow Pages ☐Yellow Book
Referred By: ☐Friend/Family ☐ Physician/Facility: ____________________
☐Pharmacy: ____________________

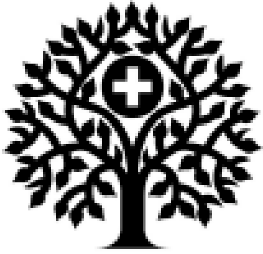
I authorize Gardens Urgent Care to release medical information to the following:
____

I authorize release of any information concerning my (or my dependent's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance purposes. I understand that I am responsible for payment in full on the date of service. I certify that the above information is complete and correct.

X____ Date: _______/_______/_________
Signature of Patient or Guardian

Patient Information Form

Welcome to Gardens Urgent Care. Please help us care for you by filling this out. If you need assistance with these forms if you have an emergency or are in severe discomfort please inform our staff.



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Date: ______________ **Reason for visit:** ______________________________________

Name: __________________________ __________________________ **Age:** ____________
Last First

____

(Check any boxes that apply to you and provide information below)

Do you have any allergies to medications, foods, latex, or other substances?

☐ No ☐ Yes, please list **Allergies:** ______________________________________

____

____

What medications do you take?

☐ None **Medications:** ______________________________________

____

____

Preferred Pharmacy Name __________________________ Telephone ______________

Cross Street __________________________ Fax ______________

Address ____

What medical problems or conditions have you ever had?

☐ Diabetes ☐ Heart condition ☐ Thyroid problem ☐ Stroke
☐ Asthma ☐ High blood pressure ☐ Pancreatitis ☐ Kidney problem
☐ Gallstone ☐ HIV ☐ Pneumonia ☐ High cholesterol
☐ Depression ☐ Bleeding disorder ☐ Back/neck problems ☐ UTI
☐ Seizure ☐ Hepatitis ☐ Prostate problem ☐ Ulcer/Reflux

Other: ____

Is there a history in the family of any of the following conditions?

☐ Diabetes ☐ thyroid problem ☐ arthritis/ lupus ☐ High cholesterol
☐ Stroke/brain aneurysm ☐ sickle cell anemia ☐ kidney stones
☐ High blood pressure ☐ heart disease ☐ kidney failure ☐ gall stones/gallbladder problems

Other: __________________________________

What surgeries or procedures have you ever had?

☐ Appendectomy ☐ Hernia ☐ Tonsils ☐ Gallbladder ☐ C-section
☐ Hysterectomy ☐ Back/neck surgery ☐ Heart surgery ☐ Pacemaker/defibrillator
☐ Catheter/stent ☐ tubal ligation

Other: ____

Do you smoke? ☐ No, never. ☐ Yes, a pack lasts _____ days. ☐ Occasionally/rarely.
☐ I quit _____ weeks/years/months (circle one) ago.

Do you drink alcohol? ☐ No, never. ☐ Yes, how much? __________. ☐ Occasionally/rarely.
☐ I quit _____ weeks/years/months (circle one) ago.

Female Patients: When was your last menstrual period? ______/_____/__________

Are you pregnant? ☐ No ☐ Yes ☐ Possibly ☐ I am trying to get pregnant

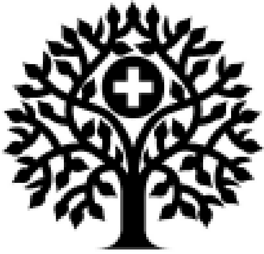
Are you breasting feeding? ☐ No ☐ Yes

PRIMARY CARE PHYSICIAN IF ANY ____________________-____________________
NAME **PHONE**

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Patient/Parent/Guardian Signature: *X* ______________________________________

Print name: __________________________ Relationship to patient: ____________________



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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time, and that I can contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my request for restrictions, but if you do agree then you are bound to abide by such restrictions.

______________________________ __________________________
Print Name Relation to Patient

X______________________________ __________________________
Signature Date

CONSENT, ASSIGNMENT, AND RELEASE

I, the undersigned, give consent to Gardens Urgent Care for evaluation and treatment of myself or my dependent child. If I, the undersigned, have insurance coverage for myself or my dependent, I hereby assign directly to Gardens Urgent Care, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions.

______________________________ __________________________
Print Name Relation to Patient

X______________________________ __________________________
Signature Date

MEDICARE AUTHORIZATION

(only for patients with medicare)

I request that payment of authorized Medicare Benefits be made either to me, or on my behalf, to Gardens Urgent Care, for any services furnished me by that physician. I authorize any holder of medical information about me to release to the health care financing administration and its agency any information needed to determine these benefits, or the benefits payable for related services. I understand my signature requests the payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms, or electronically submitted claims, my signature authorizes releasing of the information to the insurer, or agency shown. In Medicare assigned cases, the Physician or Supplier agrees to accept the charge determination of the Medicare carrier as full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and deductible are based upon the charge determination of the Medicare carrier.

______________________________ __________________________
Print Name Relation to Patient

X______________________________ __________________________
Patient Signature