



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: _____ , _____ MI
Last First

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

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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?

- | | | | |
|-------------------------------------|--|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart condition | <input type="checkbox"/> Thyroid problem | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Kidney problem |
| <input type="checkbox"/> Gallstone | <input type="checkbox"/> HIV | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Back/neck problems | <input type="checkbox"/> UTI |
| <input type="checkbox"/> Seizure | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Prostate problem | <input type="checkbox"/> Ulcer/Reflux |

Other: _____

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

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> thyroid problem | <input type="checkbox"/> arthritis/ lupus | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Stroke/brain aneurysm | <input type="checkbox"/> sickle cell anemia | <input type="checkbox"/> kidney stones | |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> heart disease | <input type="checkbox"/> kidney failure | <input type="checkbox"/> gall stones/gallbladder problems |

Other: _____

What surgeries or procedures have you ever had?

- | | | | | |
|---|--|--|--|------------------------------------|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Hernia | <input type="checkbox"/> Tonsils | <input type="checkbox"/> Gallbladder | <input type="checkbox"/> C-section |
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Back/neck surgery | <input type="checkbox"/> Heart surgery | <input type="checkbox"/> Pacemaker/defibrillator | |
| <input type="checkbox"/> Catheter/stent | <input type="checkbox"/> 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 breastfeeding? 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	