F. ILY URGENT CARE
A Professional Corporation

PATIENT INFORMATION

Last Name | First Name | Middle Name | Social Security Number

Birthdate | Age | Sex | Marital Status | Height | Weight

Address | Street | Apt # | City | State | Zip Code

Home Telephone | I.D. or Driver's Lic. # | Name of Guarantor if Minor

E-Mail:

Parent Social Security Number & Date of birth (If Minor)

PATIENT EMPLOYED BY:

Employer Name | Occupation | Work Telephone

Address | Street | City | State | Zip Code

INSURANCE INFORMATION:

Insurance Name | Telephone

Address | Street | City | State | Zip Code

Policy # | Group # | Cert. #

Name of Insured | Date of birth | Relationship to Patient

Work Related Injury | yes | No | Date of Injury

Employer Name at the Time of Injury | Telephone

Address | Street | City | State | Zip Code

REASON FOR VISIT

MEDICAL CONDITION

List any kind of allergies

Describe any Medical Condition

List all Medication you are taking

PAYMENT AUTHORIZATION:

I hereby authorize Family Urgent Care to furnish the necessary information for billing purposes. I direct the insurer to pay, directly to the physician, all benefits due to him as a result of this claim. Although covered by insurance, I am aware that I am responsible for all charges, including the balance remaining after payment of possible insurance A copy of this authorization will be as valid as the original to release any information necessary to process this claim.

Signature of Patient | Date

Authorization for Minors | Date

PATIENT PAIN DRAWING

Using the symbols below, mark the areas on your body where you feel the described sensations.

Aching/ Numbness/Pin & Needles/Burning/Stabbing/Other

^^^ === 000 XXX /// ●●●

Back

Pain in arm(s) compared with neck:

- ☐ Worse than
- ☐ Same as
- ☐ Less than

Front

Left Right Right Left

Pain in leg(s) compared with back:

- ☐ Worse than
- ☐ Same as
- ☐ Less than

Are you presently working? Yes__ No__ Patient Phone #:____________

If working: Employer__________________ Occupation:______________

I have disclosed all prior injuries, accidents and Orthopedic problems to the best of my recollection.

Patient Signature______________________________ Date____________

F[illegible]CTIONAL CAPACITIES ASSE[illegible]SMENT

Employee: **Date of Medical Appt:**
Date of Inj.:
Claim No:

Employee's work related functional duties **BEFORE** work injury.

LIFTING					
	NEVER	Seldom up to ½ hr	Occasional ½ to 3 hrs	Frequent 3 to 6 hrs	Constant
0-10 lbs					
15 lbs.					
20 lbs.					
25 lbs.					
30 lbs.					
40 lbs.					
50 lbs.					
50-75					

CARRYING					
NEVER	Seldom up to ½ hr	Occasional ½ to 3 hrs	Frequent 3 to 6 hrs	Constant	Dist. Carried

PUSHING/PULLING					
	NEVER	Seldom Up to ½ hr	Occasional ½ - 3 hrs	Frequent 3-6 hrs.	Constant
0-10 lbs.					
20 lbs.					
30 lbs.					
40 lbs.					
50 lbs.					
60 lbs					
70 lbs.					
70-100					

REACHING					
	NEVER	Seldom Up to ½ hr	Occasional ½ - 3 hrs	Frequent 3-6 hrs	Constant
Above Shoulder					
Shoulder - Waist					
Waist - Knee					
Below Knee					

PUSHING/PULLING: Please specify extremity by R – Right, L – Left or B – Both as apply to force and frequency
REACHING: Please specify extremity by R – Right, L – Left or B – Both as apply to body location and frequency

GENERAL ACTIVITIES					
	NEVER	Seldom Up to ½ hr.	Occasional Up to 3 hrs	Frequent 3-6 hrs.	Constant
SITTING					
STANDING					
WALKING					
SQUAT/KNEEL					
BEND/TWIST NECK					
BEND/TWIST WAIST					

Major/Dominant Hand: _______Right _______Left

HANDLING/FINGERING/FEELING										
	NEVER	Seldom Up to ½ hr.		Occasional ½ -3 hrs.		Frequent 3-6 hrs.		Constant	
		Lt	Rt	Lt	Rt	Lt	Rt	Lt	Rt
Simple Grip/Grasp									
Power Grip/Grasp									
Fingering/ Keyboarding									
Handling/ Repetition									

Patient's Signature

Date

Interpreter's Signature

FAMILY URGENT CARE & INDUSTRIAL MEDICAL CLINIC

Encino   Lancaster

*********** FINANCIAL RESPONSIBILITY **********

This is to inform the patient or parent(s) of minor child, that our office will Verify Insurance Coverage and will Submit Medical Claims to relevant Insurance Carrier(s).

However you will be ***responsible*** for any remaining outstanding balance **<u>not covered</u>** by your Insurance. (Co-pays, Deductibles and/or Co-Insurance) as determined by your Insurance Contract.

Co-Payments are ***<u>due</u>*** and ***<u>payable</u>*** at time of service.

(NO EXCEPTIONS)

Practice Written Acknowledgement form:

Print Name of Patient or Legal Representative:

*____

Signature of Patient or Legal Representative:

*____

Date: ________________________________

Family Urgent Care & Industrial Medical Clinic

********Office Policy********

Under the law in the state of California,
(California penal code. Chapter 1.5 Invasion of privacy 630-638 Cited 3/25/2015)
any recording of an individual by another without his or her knowledge is a crime.
Please be informed that portable device or phone recordings (video or audio) are not permitted in the examination rooms.
If we discover any recording, we will immediately stop the exam and will request what has been recorded be deleted.
Prohibition of recording is to protect patients' privacy.

Practice Written Acknowledgement form;

Signature of Patient or Legal Representative

*______________________________________

Printed Name of Patient or Legal representative

____

Date:________________________