ALL MED
URGENT CARE
WALK-IN CLINIC

Patient Demographic Form (Please PRINT) MRN	Date

PATIENT INFORMATION

Last Name	First Name	Middle Initial	Nickname/ AKA

Date of Birth	Preferred Language:	Gender [ ] Male [ ] Female

Marital Status	[ ] Married	[ ] Single	[ ] Divorced	[ ] Life Partner	[ ] Separated	[ ] Widowed	[ ] Other

Race (Optional)	[ ] Black- Non Hispanic	[ ] American Indian/ Alaskan Native	[ ] Hispanic	[ ] Asian Pacific Islander	[ ] White- Non Hispanic	[ ] Other

Home Address	Apt#	City	State	Zip Code

Home Phone	Cell Phone	Other Phone [ ] Cell [ ] Pager [ ] Fax

Email Address	[ ] Active Duty Military	[ ] Employed Full- Time	[ ] Retired	[ ] Student Full- Time
	[ ] Child	[ ] Employed Part- Time	[ ] Self Employed	[ ] Student Part- Time
	[ ] Disabled	[ ] Not Employed	[ ] Home Maker	[ ] Other

Employer	Employer Phone

PHYSICIAN REFERRAL INFORMATION

Primary Care Physician	Referring Physician

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient	[ ] Self (If self, skip to Emergency/ Next to Kin)	[ ] Spouse	[ ] Parent	[ ] Other

Last Name	First Name	Middle Initial

Date of Birth

Home Address	Apt#	City	State	Zip Code

Home Phone	Work Phone	Other Phone [ ] Cell [ ] Pager [ ] Fax

Employer	Employment Status	[ ] Active Duty Military	[ ] Employed Full- Time	[ ] Retired	[ ] Student Full- Time
		[ ] Child	[ ] Employed Part- Time	[ ] Self Employed	[ ] Student Part- Time
		[ ] Disabled	[ ] Not Employed	[ ] Home Maker	[ ] Other

Employer Phone

EMERGENCY / NEXT OF KIN CONTACT INFORMATION

Last Name	First Name	Relationship to Patient

Home Address	Apt#	City	State	Zip Code

Home Phone	Cell Phone	Other Phone [ ] Cell [ ] Pager [ ] Fax

115-20 Liberty Ave, S Richmond Hill, NY – 11419, PH: (718) 656-0400
105-34 Rockway Blvd, Ozone Park, NY – 11417
55W Old Country Road, Hicksville, NY -11801
Email: allmedurgentcare1@gmail.com

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REASON OF VISIT

1. _____
2. _____
3. _____
4. _____

CURRENT MEDICATIONS (PLEASE LIST)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

None ☐

PHARMACY

Name-: _____ Address-: _____

MEDICAL HISTORY (PLEASE CHECK ☑ YES OR NO)

Diabetes	Yes ☐	No ☐		Hypertension	Yes ☐	No ☐
Hyperlipidemia	Yes ☐	No ☐		Hyperthyroidism	Yes ☐	No ☐
Cardiovascular	Yes ☐	No ☐		Tobacco	Yes ☐	No ☐

Others (Please Specify)

_____

ALLERGY (PLEASE LIST)

Medicine	Yes ☐	No ☐	If yes state medication/s _____
Food	Yes ☐	No ☐	If yes state what food/s _____
Seasonal	Yes ☐	No ☐	If yes during which season of the year _____

FAMILY HISTORY

1. Mother: Alive/ Deceased _____	2. Father: Alive/ Deceased _____
3. Siblings: Brothers _____ Sisters _____	4. Children: Boys _____ Girls _____

SOCIAL HISTORY (PLEASE CHECK ☑ YES OR NO)

Smoking	Yes ☐	No ☐		If yes	Everyday ☐	Occasional ☐
Drinking	Yes ☐	No ☐		If yes	Everyday ☐	Occasional ☐
Drugs	Yes ☐	No ☐		If yes	Everyday ☐	Occasional ☐

SURGERY / HOSPITALIZATION

Have you ever done a surgery in the past _____ (if yes please indicate what surgery and the year)

_____

Have you ever been hospitalized in the past _____ (if yes please indicate why and the year)

_____

Signature _____ Date _____

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ALL MED URGENT CARE WALK-IN CLINIC

Healthix

Authorization for Access to Patient Information Through a Health Information Exchange Organization		
Patient Name:	Date of Birth:	Patient Identification Number:
Patient Address:		

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow **ALL MED URGENT CARE PC** to obtain access to my medical records through the health information exchange organization called Healthix. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Healthix is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit Healthix's website at www.healthix.org.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice.

I can fill out this form now or in the future.

I can also change my decision at any time by completing a new form.

☐ 1. I **GIVE CONSENT** for ALL MED URGENT CARE PC to access ALL of my electronic health information through Healthix to provide health care.

☐ 2. I **DENY CONSENT** for ALL MED URGENT CARE PC to access my electronic health information through Healthix for any purpose.

If I want to deny consent for all Provider Organizations and Health Plans participating in Healthix to access my electronic health information through Healthix, I may do so by visiting Healthix's website at www.healthix.org or calling Healthix at 877-695-4749.

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative:	Date:
_____	_____
Print Name of Legal Representative (if applicable):	Relationship of Legal Representative to Patient (if applicable)
_____	_____

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General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be Informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards Involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any Identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are Indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommend; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it Is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, l will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to Its contents.

Signature of Patient or Personal Representative	**Date:**
Printed Name of Patient or Personal Representative	**Relation to Patient**
Printed Name of Witness	**Employee Job Title**
Signature of Witness	**Date:**

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OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number N/A
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:
115-20 Liberty Ave, S Richmond Hill, NY – 11419, PH: (718) 656-0400

9(a). Specific information to be released:

☐ Medical Record from (insert date) _____ to (insert date) _____

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

_____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ☐ At request of individual ☐ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**