First Care Walk-In Clinic
2912 West Waters Avenue
Tampa, FL 33614
Phone: 813-443-4611
Fax: 813-443-4754
www.firstcarewalkinclinic.com

Patient Information Form

Patient Information:

Patient Name:________________________________ DOB: ________________

Address:____

City: ________________ State:____________ Zip Code: ______________

Phone #: ____________________ Email Address:______________________________

SS#______________________________

Pharmacy Information:

Pharmacy name: ______________________ Pharmacy #:______________________

Guarantor Information(ONLY fill out if you are the parent/guardian of minor child):

Parent/Guardian Name:____________________________ DOB: ______________

SS#: ________________________________

Emergency Contact:

Name: _________________________________ Phone #:______________________

Address: ____

AUTHORIZATIONS

I hereby authorize and consent to medical care and/or minor surgical care deemed advisable by the doctor on duty at the time of my visit in order to diagnose and provide treatment. In addition, I fully understand office policy regarding medical fees and agree to payment of fees at time professional services are rendered. I understand that any lab specimens drawn or collected here, that is not performed here, will be sent to an independent laboratory and will be billed separately by the independent laboratory. I agree to be fully responsible for all charges including any legal fees and /or collection fees in the event of non-payment.

______
INITIALS

I hereby authorize First Care Walk-In Clinic to release any and all medical information in connection with the services rendered for health insurance purposes. I also hereby give my permission to send a copy of my medical records to my primary care physician's office. I release the facility from any liability which may arise as a result of use of information contained in the records listed. I hereby authorize my insurance carrier to mail payment directly to First Care Walk-In Clinic for any medical/ surgical services.

______
INITIALS

Signature: ______________________________

Date:_______________

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Date: ____________________

Name: ______________________________ Birthdate: __________ Sex ______ Race ______

Height ______

Weight ______

Health History of the Patient

	Yes	No
Stroke		
Heart Trouble		
High Blood Pressure		
Diabetes		
Arthritis Type ____		
Gout		
Seizures		
Mental Illness		
Kidney Trouble/Stones		
Cancer Type ______		
Bleeding disorders		
Alcoholism		
Serious injuries		
Lung Disease		
Tuberculosis		
Phlebitis		
Anemia		
Stomach Ulcers		
Liver Trouble		
Thyroid Trouble		
HIV		
Hepatitis		
Osteoporosis		
Other Illnesses		

Explain all Yes Answers:

List all Surgeries (include approx. dates)

Allergies to Medicine: (None [ ]).

Family History

	Yes	No
Stroke		
Heart Trouble		
High Blood Pressure		
Diabetes		
Arthritis		
Gout		
Seizures		
Mental Illness		
Kidney Trouble/Stones		
Cancer		
Bleeding disorders		
Alcoholism		
Other		

Explain all Yes answers:

Cause of death parents, brothers, or sisters:

Current Medications/Vitamins/ Supplements and dosage:

Review of Systems

Do you currently have?

	YES	NO
Weight Loss or Gain		
Rash or Itching		
Change in Vision		
Abnormal Heartbeat		
Heart or Chest pain		
Shortness of Breath		
Fever		
Abdominal Pain		
Diarrhea		
Nausea or Vomiting		
Bowel/Bladder incontinence		
Frequent urination		
Burning on urination		
Urination Urgency		
Muscular Weakness		
Joint Pain		
Joint Swelling		
Numbness		
Bleeding Tendency		
Lymph Node Enlargement		

Married [ ] Single [ ] Divorced [ ]
Widowed [ ]

Number of Children __________
Presently Living Alone? Yes [ ] No [ ]

Do you smoke? Yes [ ] No [ ]
Smoke ____ packs per day

Alcohol: Never [ ] Occasional [ ]
Moderate to Heavy [ ]

Do you use Illegal drugs Yes [ ] No [ ]

Patient Signature

MD Initials

PATIENT ACKNOWLEDGEMENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Potability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice to Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this consent

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Patient Name (print): ______________________________

This Ackowledgement was signed by: ______________________________
Patient or Legal Representative

Relationship to Patient (if other than patient): ______________________________

Date: _____/_____/_____

Witness Signature: ______________________________
Practice Representative

Date: _____/_____/_____