SUN MEDICAL EXPRESS WALK IN CLINIC

Patient Information Sheet **Date_____/_____/______**

NAME: LAST____FIRST ____________________________ MIDDLE INITIAL __________________

ADDRESS ____ CITY __________________________ STATE _________ZIP___________

HOME PHONE (______) ______ - _______ **CELL PHONE** (_______) ______ - _______ **WORK PHONE** (______) ______ - ________ EXT. _____

DATE OF BIRTH _____/_____/______ **SEX** ☐**F** ☐**M** **SSN#** ______ / ______ / _______ **E-MAIL**____________________@_______________

PRIMARY CARE DOCTOR ____**PHONE NUMBER**____________________________________

HOW DID YOU HEAR ABOUT US? MAIL FRIEND/FAMILY NEWSPAPER BILLBOARD OTHER_____________________________________

MARITAL STATUS: ☐ SINGLE ☐ DIVORCED ☐ LEGALLY SEPARATED ☐ PARTNER
☐ MARRIED (SPOUSE NAME _____________) ☐ WIDOWED ☐ UNKNOWN

EMPLOYER NAME ____ ADDRESS ____

EMPLOYMENT STATUS: ☐ FULL TIME ☐ NOT EMPLOYED ☐ RETIRED
☐ PART TIME ☐ SELF EMPLOYED ☐ ACTIVE MILITARY

STUDENT STATUS: ☐ FULL TIME ☐ PART TIME ☐ NOT A STUDENT

WHO WILL THE BILL BE SENT TO? ☐ SELF ☐ OTHER RELATIONSHIP______________________

NAME___________________________________ ADDRESS ____

CITY____________________________ STATE ________ ZIP__________________

SSN#__________________________________ or DL#________________________DOB_____/_____/______

EMERGENCY CONTACT:
NAME LAST_______________________________ FIRST ______________ RELATIONSHIP__________________

ADDRESS________________________________ CITY _____________________ STATE ______ ZIP __________

HOME PHONE (_______) _______ - _________ WORK PHONE (_______) _______ - _________ EXT. _______

PERMISSION TO LEAVE MESSAGE: HOME ☐YES ☐NO WORK ☐YES ☐NO

AUTHORIZATION TO RELEASE INFORMATION TO: NAME _________________________ RELATIONSHIP ________
PHONE (_______) _______ - ___________

PHARMACY:
NAME _______________________________ LOCATION _________________________
PHONE (_______) _______ - ____________ FAX (_______) _______ - _____________

INSURANCE INFORMATION YOU ONLY HAVE TO FILL OUT THE HIGH LIGHTED AREAS

PRIMARY INSURANCE _________________________ **POLICY HOLDER NAME**_________________________________

COPAY: $_____________ **or** _____________**% (Patient's copay or coinsurance is due at the time services are rendered)**

POLICY HOLDER SEX ☐ F ☐ M **POLICY HOLDER DOB**_____/_____/______

POLICY HOLDER SSN # _______ - _______ - ________ **POLICY HOLDER RELATIONSHIP TO PATIENT** ______________

ID#____ GROUP #____

SECONDARY INSURANCE _________________________ **POLICY HOLDER NAME**_________________________________

COPAY: $_____________ **or** _____________**% (Patient's copay or coinsurance is due at the time services are rendered)**

POLICY HOLDER SEX ☐ F ☐ M POLICY HOLDER DOB_____/_____/______

POLICY HOLDER SSN # _______ - _______ - ________ POLICY HOLDER RELATIONSHIP TO PATIENT ______________

ID#____ GROUP #____

Sun Medical Express Walk In Clinic

I hereby give Sun Medical Express Walk+In Clinic consent for medical treatment.

Date: ____________________ Print patient name:_______________________________________
Signature:____
Patient/Guardian

In compliance with the HIPAA Privacy Act, Sun Medical Express Walk In Clinic will not release information to any party without the patient's permission. By signing below you are giving Sun Medical Express Walk In Clinic permission to file to your insurance company(s).

As your physicians at Sun Medical Express Walk In Clinic we are committed to providing you with the best possible medical care. In order to achieve this goal, we need your assistance, and your understanding of our payment policy.

PAYMENTS FOR SERVICE IS DUE AT THE TIME SERVICES ARE RENDERED. We accept cash, personal checks, MasterCard, Visa, and Discover. Returned checks are subject to a service charge of $25-40.00 or 5% whichever amount is greater, and you will lose the privilege to write checks in our office.

COMMERCIAL INSURANCE- CO-PAYMENT AND DEDUCTIBLE MUST BE PAID AT THE TIME OF SERVICE. Because we are under contract with your insurance company, we will file your insurance, provided the information is current and given to our office in a timely manner.

HMO INSURANCE- It is your responsibility to obtain a referral from your PCP prior to your appointment. If a referral is not obtained, the appointment will be rescheduled.

WORKERS' COMPENSATION- We will not file Workers' Compensation Claims. It is your responsibility to pay for these claims and have your employer reimburse you.

CHILDREN OF DIVORCED PARENTS – PAYMENT IS DUE AT THE TIME OF SERVICE no matter who is responsible by order of the divorce decree.

FINANCIAL AGREEMENT-We will gladly discuss your proposed treatment and do our best to answer any questions relating to your insurance. You must realize, however that:

1. **Your insurance is a contract between you, your employer, and the insurance company. We are not party to that contract.** ***To enable our office to file your insurance, you must provide accurate information at each visit.***
2. **Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover (i.e.: x-rays, labs, supplies, elective procedures, and pre-existing conditions).**
3. **Due to timely filing limits for insurance companies, you have 60 days from the date services are rendered to provide our office with updated insurance information. If the information is not received within 60 days, you will be responsible for the charges.**

We must emphasize that as your medical care providers, our relationship and concern is with you and your health, not the insurance company. **ALL CHARGES ARE YOUR RESPONSIBILTY FROM THE DATE SERVICES ARE RENDERED.** On any balance on your account after 90 days, including those that insurance has not paid, collection action will be taken. We realize that emergencies do arise and may affect timely payment of your account. If such cases occur, please contact us promptly for assistance in the management of your account.

*If it becomes necessary to collect any sum due through an attorney, then the patient agrees to pay all reasonable costs of collection, including attorney's fees, whether suit is filed or not.

*If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

I have read and understand the above Financial Policy.

____ ________________________
Patient/Legal Guardian signature **Date**

____ ________________________
Witness

Sun Medical Express Walk-In Clinic

Confidential

MEDICAL INFORMATION SHEET

Name ______________________________________ Date ____________________

Please fill out all spaces and mark N/A to any section not applicable. Thank you.

1. What are you here to see us for today? ______________________________________

____

2. Is this visit work related? ____________________________
3. Is this visit related to an auto accident?_______________
4. Could you be pregnant?____________________________

5. Medication Use:

Please list any medication(s) including alternative or non-prescribed therapies (herbal, vitamins, homeopathies) you take. Include any prescription tablets, inhalers or nasal sprays and over-the-counter medicines such as aspirin, Tylenol, allergy or cold pills, etc.

Medication	Dosage	Reason for use

6. List any Major medical problems: ______________________________________

____

7. Have you ever been diagnosed with:

Cancer	yes	no
Diabetes	yes	no
Heart Disease	yes	no
High Blood pressure	yes	no
Heart Attack	yes	no
Stroke	yes	no
Psychiatric illness	yes	no
Lung disease	yes	no
(asthma, COPD, emphysema) (Circle Which One)	yes	no

If yes to any of the above, please tell us when and how treated:

8. **Have you ever had an allergic reaction to a medication? yes no**

If yes, please complete the following:

Medication	Reaction caused

9.Family History:

PLEASE CIRCLE : Asthma, High Blood Pressure, Cancer, Diabetes, Heart Disease, Stroke

10. Have you ever had surgery? yes no

Please list any surgeries and their dates: ______________________

____

____

11. Have you ever been hospitalized? yes no

Please list any hospitalizations, when and for what reason: ______________

____

____

12. Social History. Do you:

a) Smoke/chew tobacco? yes no packs / day? ______________

b) Use alcohol? yes no drinks / day? ______________

c) Use illegal drugs? yes no list: ______________

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. I authorize the healthcare staff to perform the necessary services I may need.

Signature of patient or parent: ______________________________

Date: ______________________________