Bear Valley Urgent Care
12186 Hesperia Rd. Victorville, CA 92395
Ph: (760) 381-8848 Fax: (760) 381-8810

Last Name: ______________________________ **First Name:** ________________________ **Middle Initial:** ______

Date of Birth: ____________________________________ ☐ **Female** ☐ **Male**

Reason for visit: ____ **How many days/weeks:** _________

Is this a work-related injury/problem? ☐ **Yes** ☐ **No**

Medical History:

High Blood Pressure	Yes	No
Diabetes 1 / 2	Yes	No
Ulcers	Yes	No
Heart Murmur / Valve Disorder	Yes	No
Stroke	Yes	No
Heart Attack	Yes	No
Cancer: ______________________	Yes	No
Gallstones	Yes	No
Kidney Stones	Yes	No
Blood Transfusion	Yes	No
Immunological Disorders	Yes	No
Diverticulosis	Yes	No

Thyroid Problems	Yes	No
Asthma	Yes	No
C.O.P.D	Yes	No
Depression	Yes	No
Anxiety	Yes	No
High Cholesterol	Yes	No
Other: ________________________	Yes	No

Alcohol Use	Yes	No
Tabacco Smoker	Yes	No
Recreational Drugs	Yes	No

Family History: Please indicate health status or cause of death, disease related to presenting problem and or hereditary or high-risk diseases. **NONE**

Mother: ____ Children: ______________________________________

Father: ____ Siblings: ______________________________________

Operations/ Surgeries: **NONE**

Name of Operation/Surgery	Year	Complications
1. ___________________________________	______________________	_______________
2. ___________________________________	______________________	_______________
3. ___________________________________	______________________	_______________

Medications Dosage / Frequency **NONE**

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

Allergies / Reaction **NONE**

1.
2.
3.
4.

Patient Signature: ________________________ **Print Name:** __________________________ **Date:** ______________

(If patient is a minor; parent or guardian will sign above.)

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PATIENT REGISTRATION

Last Name: ________________________________ **First Name:** __________________________ **Middle Initial:** ______

Date of Birth: ______________________________ ☐ **Female** ☐ **Male** **SSN:** ________-________-________

Mailing Address: ____ **Apt/Suite/Unit:**_____________

City: ____ **State:** ________________ **Zip Code:** ____________________

Phone Number: _________________________________ **Email:** ____

Marital Status: Married • Single • Divorced • Separated • Widow • Prefer not to answer

Race: White • African American • Asian • Eastern • Other:_________________ **Ethnicity:** ____________________

Primary Language: ____ **Do you need a translator:** ☐ **Yes** ☐ **No**

Emergency Contact: ________________________ **Phone:** _____________________ **Relationship:**_________________

Emergency contact is required by your insurance, if you REFUSE to provide one, please initial here: ___________

Pharmacy Name: ______________________ **Address:** ____

Employer: ____ Occupation: ________________________

Address: ____ Apt/Suite/Unit:_____________

City: ____ State: ________________ Zip Code: ____________________

Work Phone Number: ____

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INSURANCE INFORMATION

Primary Insurance: ____

Member ID Number: ____

Secondary Insurance: ____

Member ID Number: ____

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Minor Child Consent

I, being the parent/guardian of ____ do hereby request and authorize Bear Valley Urgent Care, providers and staff to perform necessary services for my child, including but not limited to radiology, labs and administration of medications and anesthetics which are deemed advisable by the physician.

Signature: ____ **Date**: __________________________________

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Patient Name: ____ **DOB:** ________________

CONSENT TO MEDICAL SERVICES: The undersigned consent to the procedures which may be performed, including emergency treatment or services, and which may include but are not limited to laboratory procedures, x-ray examination medical treatment or procedures, services rendered to the patient under the general and special instructions of the patient's physician, and to participate in the patient and employee protection program.

PRESCRIBE: The undersigned authorizes bear valley urgent care to request and use patient's prescription medication history from other healthcare providers and/or third-party pharmacy benefit payers for treatment purposes.

RELEASE OF INFORMATION: The urgent care may disclosure all or any part of the patient's record to any person, company or corporation which is or may be liable under a contract to the urgent care or to the patient or to a family member or employer of the patient for all or part of the urgent care charge, including but not limited to hospital or medical service companies, insurance companies, workman's compensation, or welfare funds. The patient's record may be forwarded to the primary care physicians or to another facility in the event of transfer.

ASSIGNMENT OF BENEFITS: Insurance is billed as a courtesy to the patient and is not an obligation. The undersigned authorizes, whether he/she signs as agent or as patient, direct payment of any insurance benefits otherwise payable to or on behalf of the urgent care, pursuant to this authorization, by an insurance company shall discharge said insurance company of all obligations under a policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment and any applicable co-payments, co-insurances, or deductible amounts.

FINANCIAL RESPONSIBILITY: If the patient was evaluated by a physician, physician assistant and/or nurse practitioner at Bear Valley Urgent Care and was advised to go to another facility or physician for further treatment and evaluation, the undersigned agrees that they are responsible for any applicable co-payments, co-insurances or deductible amounts.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: "I hereby acknowledge that I have received a copy of the practice's *NOTICE OF PRIVACY PRACTICES.* I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand that the practice will offer me updates to this *NOTICE OF PRIVACY PRACTICES* should it be amended, modified, or changed at any time."

I agree to accept full financial responsibility for services rendered to the patient and to accept the terms of the assignment of insurance benefits.

Signature: ____ **Date:** ____________________

(If patient is a minor, patients guardian or parent signature.) If other than patient please print name.

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Authorization to Fax Medical Records to Primary Care

____	______/________/______	____________________________
Patient's Name (Last, First, Middle Initial)	**DOB**	**Phone Number**

____________________________________	___________________________	___________________________
Primary Care Physician	**Phone Number**	**Fax Number**

I hereby authorize ***BEAR VALLEY URGENT CARE*** to provide a copy of my medical records to the primary care physician (PCP listed above to allow for continuity of care. The records sent to my PCP will include encounter notes, medication, and radiology reports (if applicable from my visit).

I understand that my medical records will not be shared with any additional person, medical provider or organization without a signed authorization for Release of Medical Information.

This authorization will automatically expire six months from the date of execution unless otherwise noted:
____.

I understand that information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California Lae and may no longer be protected by federal confidentiality law (HIPPA). The receipt of this information is requested not to re-disclose this information without my authorization for disclosure. ***BEAR VALLEY URGENT CARE,*** its employees, officers and physicians are hereby released from any legal responsibility or liability for improper re-disclosure of the above information to the extent indicated and authorized herein.

A copy or photocopy of this authorization will serve the dame validity as though an original had been presented.

____	___________________________	_______________
Signature of Patient/Guardian/Legal Representative	**Print Name/Relationship**	**Date**