Caldwell IMMEDIATE CARE

2523 S 10th Ave.
Suite 103
Caldwell, ID 83605

Phone: (208) 459-7788
Fax: (208) 455-3277
www.cicimmediatecare.com

PATIENT INFORMATION

First name:	Middle Initial:	Last name:
Date of Birth:	Age:	Sex: ❑ Male ❑ Female
Permanent Address:		
City:	State:	Zip:
SSN #:	Home/Cell:	
Email:		
Preferred Language: ❑ English ❑ Spanish		
Race: ❑ White ❑ Black or African American ❑ Native Hawaiian or other Pacific Islander ❑ American Indian or Alaska Native ❑ Asian		
Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino		
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed		
Primary Care Physician:	Pharmacy Name/Location:	

INSURANCE INFORMATION *(please provide copies)*

❑ *Check here if patient is uninsured*

Name of Insurance Company:	Subscriber's Name:
Subscriber's DOB:	Subscriber's phone number:
Policy Number (ID):	Group Number:

RESPONSIBLE PARTY INFORMATION

First name:	Middle Initial:	Last name:
Permanent Address:		
City:	State:	Zip:
Home/Cell:	DOB:	Relationship:

EMERGANCY CONTACT INFORMATION

First name:	Middle Initial:	Last name:
Permanent Address:		
City:	State:	Zip:
Home Phone:	Cell:	Relationship:

Have you been seen here before? ❑ Yes ❑ No

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SUMMARY OF ACKNOWLEGMENT OF RECEIPT FOR NOTICE OF PRIVACY PRACTICE

The Organization Health Care Arrangement (OHCA) of Caldwell Immediate Care Center will provide with a copy of their "Notice of Privacy Practices". The OHCA will use and disclose health information about you for the purpose of treatment and/or alternatives, payment and individuals involved in your care and for health care operations.

Caldwell Immediate Care employees and healthcare providers will show you the respect, maintain your dignity and make you feel as comfortable as possible while you are receiving care from us. Good healthcare is a partnership. You can help by providing accurate and timely information to your heart health care provider asking questions and following your individualized treatment plan.

Information about you and your care will be kept confidential (private) your medical records are private and only you and other authorized people or agencies are allowed to see them. You have the right to see and obtain copies of your medical records. **(Fees may apply.)** To obtain your records you will need to give us a request in writing it may take a few days for us to make your medical records available.

We reserve the right to change the "Notice of Privacy Practices". We also reserved the right to make the revised or changed notice affective for health information we already have about you as well as any information received in the future. We will post a copy of the most current notice of privacy practices please read the full notice of privacy practices that has been given to you it explains our privacy practices in further detail.

I hereby acknowledge that I have received a copy of the full "Notice of Privacy Practices"

Patient Name:	Date:
Signature of Patient or Legal Representative:	Relation to Patient:

Please list name of family members of friends you authorized to receive/discuss your health care

Name:	Relationship:

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General Information for Insured/Uninsured Patients

- We ask for payment at the time of service unless other plans are pre-arranged.
- We are required to collect your insurance plan's co-payment at the time of service.

Please remember that insurance is considered a method of reimbursing the patient for fee paid to the doctor and is not substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

I authorize the release of any medical information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance and other agency reimbursements to Caldwell Immediate Care. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said Insurance, I hereby authorize said assignee to release all information necessary to secure the payment.

General Information on Payment and Procedure

1. If after sixty (60) days, insurance has not responded to the claim, the billing is expected to be paid in full by the responsible party. We do require a payment within 30 days of time of service.
2. Patients with health insurance should remember that serviced are rendered and charged to the patient. Any dispute over an insurance claim is a matter between the patient and insurance carrier. Should a dispute arise, we will make every effort to help resolve the claim.

Authorization and Agreement for Treatment

1. CONSENT TO TREATMENT: I understand that medical treatment will be performed by independent physicians, their assistants, and employees of Caldwell Immediate Care Center between the working hours of 8:00am and 7:00pm. Caldwell Immediate Care Center is not responsible for the care between the hours of 7:00pm and 8:00am. I hereby give my authorization and consent to treatment and procedures, and certify that no guarantee or assurance has been made as to the results of such treatment and procedures.

Consent for Electronically Prescribing

- ePrescribing is way for providers to send electronically an accurate, error free, and understandable prescription from Caldwell Immediate Care to the pharmacy of your choice. EPrescribe includes:
    - Formulary and benefit transactions- Gives providers information about which drugs are covered by your drug benefit plan.
    - Refill notification- Allows providers to receive electronic refill requests from the pharmacy.

Understanding all the above, I hereby consent Caldwell Immediate Care to enroll me in the ePrescribe program.

Signature: Date:

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PATIENT HISTORY

Patient Name:	DOB:

Allergies: _____

Do you have or have you been treated for any of the following:

Arthritis	❑ Yes	❑ No	**Heart Attack Year:**	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	**Stroke**	❑ Yes	❑ No
COPD/Emphysema	❑ Yes	❑ No	**High Cholesterol**	❑ Yes	❑ No
Sleep Apnea	❑ Yes	❑ No	**Blood clots**	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No	**Bleeding disorder**	❑ Yes	❑ No
Thyroid	❑ Yes	❑ No	**Acid reflux**	❑ Yes	❑ No
High Blood Pressure	❑ Yes	❑ No	**Ulcers**	❑ Yes	❑ No
Irregular Heart Beat	❑ Yes	❑ No	**Hepatitis**	❑ Yes	❑ No
Seizures	❑ Yes	❑ No	**Teeth/Gum Disease**	❑ Yes	❑ No
Mental Health	❑ Yes	❑ No			

Other Medical Conditions: _____
Surgical History (list all prior surgeries and approximate dates): _____
_____

SOCIAL/CULTURAL HISTORY

Do you use alcohol?		
❑ Yes	❑ No	❑ Patient declined to answer
Do you use recreational drugs?		
❑ Yes	❑ No	❑ Patient declined to answer
Do you use tobacco product and are you interested in quitting?		
❑ Yes	❑ No	❑ Patient declined to answer

MEDICATIONS, VITAMINS AND HERBAL SUPPLEMENTS

Medication	Strength	Number of pills & frequency
Example: Tylenol	*500mg*	*1- twice daily*

FAMILY HISTORY

Father:	❑ Living	❑ Deceased	**Mother:**	❑ Living	❑ Deceased
Siblings:	❑ Living	❑ Deceased	**Children:**	❑ Living	❑ Deceased

Alcoholism:	❑ Father	❑ Mother	❑ Siblings
Anemia:	❑ Father	❑ Mother	❑ Siblings
Asthma:	❑ Father	❑ Mother	❑ Siblings
Arthritis:	❑ Father	❑ Mother	❑ Siblings
Mental Health:	❑ Father	❑ Mother	❑ Siblings
Cancer:	❑ Father	❑ Mother	❑ Siblings
COPD/Emphysema:	❑ Father	❑ Mother	❑ Siblings
Dementia:	❑ Father	❑ Mother	❑ Siblings
Diabetes:	❑ Father	❑ Mother	❑ Siblings
DVT (Blood Clot)	❑ Father	❑ Mother	❑ Siblings
Heart Disease:	❑ Father	❑ Mother	❑ Siblings
High Cholesterol:	❑ Father	❑ Mother	❑ Siblings
Kidney Disease:	❑ Father	❑ Mother	❑ Siblings
Migraines:	❑ Father	❑ Mother	❑ Siblings
Osteoporosis:	❑ Father	❑ Mother	❑ Siblings
High Blood Pressure:	❑ Father	❑ Mother	❑ Siblings
Stroke:	❑ Father	❑ Mother	❑ Siblings
Thyroid Disease:	❑ Father	❑ Mother	❑ Siblings

REVIEW OF SYSTEM:

Are you currently having any of the following?

Cardiovascular			**Gastrointestinal**		
Chest pain	❑ Yes	❑ No	Stomach pain	❑ Yes	❑ No
Palpitations	❑ Yes	❑ No	Weight gain	❑ Yes	❑ No
Head/Eyes			Weight loss	❑ Yes	❑ No
Visual changes	❑ Yes	❑ No	Nausea	❑ Yes	❑ No
Light sensitivity	❑ Yes	❑ No	Vomiting	❑ Yes	❑ No
Blurred vision	❑ Yes	❑ No	Diarrhea	❑ Yes	❑ No
Double vision	❑ Yes	❑ No	Trouble swallowing	❑ Yes	❑ No
Headaches	❑ Yes	❑ No	**Ears/Nose/Throat**		
Respiratory			Easy bleeding	❑ Yes	❑ No
Cough	❑ Yes	❑ No	Face or neck lumps	❑ Yes	❑ No
Wheezing	❑ Yes	❑ No	Nose bleeds	❑ Yes	❑ No
Coughing blood	❑ Yes	❑ No	**Musculoskeletal**		
Snoring	❑ Yes	❑ No	Hand/foot swelling	❑ Yes	❑ No
Skin			Back/neck problems	❑ Yes	❑ No
Bruising	❑ Yes	❑ No	**Neurological**		
Rashes	❑ Yes	❑ No	Muscle weakness	❑ Yes	❑ No
Skin lesions	❑ Yes	❑ No	Numbness/tingling	❑ Yes	❑ No
Abnormalities	❑ Yes	❑ No	Dizziness/instability	❑ Yes	❑ No
Blood/Lymph			Lightheadedness	❑ Yes	❑ No
Bruising/Clotting	❑ Yes	❑ No			
Easy Bleeding	❑ Yes	❑ No			

Reason for visit: _____