How did you hear about us? *Internet/Friend/Other_____ INSURANCE/COPAY___SELF PAY___*

PATIENT HISTORY FORM ***DATE:_____***

PATIENT NAME: _____ DOB: _____ AGE: _____

Note to return to work/school (circle one) Yes No

REASON FOR VISIT: _____

MEDICATIONS (PRESCRIPTION AND OVER THE COUNTER):

_____

_____

ALLERGIES (INCLUDES MEDICATIONS, TYPE OF REACTION):

_____

IMMUNIZATIONS (YEAR): TDAP_____ FLU_____ PNEUMOVAX_____SHINGLES_____

PAST MEDICAL HISTORY: (LIST ALL CONDITIONS):

_____

SCREENINGS (YEAR COMPLETED): MAMMO____ PAP____ BONE DENSITY____ COLONOSCOPY____

FAMILY MEDICAL HISTORY: _____
CARDIAC HISTORY UNDER THE AGE OF 55: YES/NO _____

SMOKING: YES / NO / FORMER ALCOHOL: YES / NO LMP (Female Only): _____

----------OFFICE USE ONLY BELOW----------

VITAL SIGNS: Height_____ Weight_____ Temp____ BP_____ /_____ HR____ RR____ SPO2____

REVIEW OF SYSTEMS: N, V, D, fever, weight loss, night sweats, travel, sexually active

_____

PHYSICAL EXAM: _____

TESTS ORDERED/RESULTS: _____ In lab book ☐

DIAGNOSIS: _____

TREATMENT: _____

FOLLOW UP: _____

PHARMACY INFORMATION:

NAME_____ ADDRESS_____ ZIP_____ PHONE_____

PRIMARY CARE PROVIDER NAME: _____ PHONE #: _____

Room _____ Student _____ Time _____

Your Family Walk-In Clinic
Info@yourfamilywalkinclinic.com
Office: 813-792-8555
Fax: 813-792-0555
17929 Hunting Bow Circle, Lutz, FL 33558

Patient Name: _____

CONTRACT TERMS

In order to protect our patients from outstanding debt and the risk of collections, an agreement has been made to improve the processing methods once insurance liabilities have been determined. This is not a receipt. This is a contract agreeing to pay for services once patient liability has been determined. The terms of this contract are as follows:

X _____(guarantor initials) I agree to allow the practice to charge my credit card for the balance due, as determined by the final adjudication of this and all other claims included under this contract. I agree to the final adjudication amount as defined by my insurance company, with exceptions as noted below. I agree to these charges under the following conditions:

a) The charges will take place upon receipt, or within a few days of the final explanation of benefits from my insurance company
b) The amount charged to my card will not exceed $200.00
c) I will receive a bill from the practice for any balance greater than $200.00 for which I am liable.
d) I will receive a receipt for any amount charged to my card once the transaction has been executed

Signature: **X**_____

(Cardholder signature) I agree to pay the above total amount according to the card issuer agreement.