# Only Choice Urgent Care

Jackie Wurtz, FNP
Ruth Teague, FNP
DJ Quality Care, LLC
11515 East FM 1960, Ste. C
Huffman, TX 77336
Office: (281) 324-1550
Fax: (281) 324-1555

## NEW PATIENT DEMOGRAPHICS

**Name** _____ ____. _____ **DOB** ____/____/_____
**Sex:** M F
**Race** _____ **Marital Status** _____ **Social Security #** _____ - _____ - _____
**Address** _____ City/State _____
Zip _____ **Phone** _____ - _____ - _____ Cell _____ - _____ - _____ Work
_____ - _____ - _____

**Employed?** YES NO STUDENT **Where?** _____ Full time part time

**Personal Email** _____@_____.com

**What pharmacy would you like to use?**

_____ City _____

**Primary Insurance**

_____
Subscriber ID#_____
Group# _____

**Secondary Insurance**

_____
Subscriber ID# _____
Group# _____

**Diagnosis:** _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

**Medication:** _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

**Allergies:**
_____ _____ _____
_____ _____ _____
_____ _____ _____

**Previous Doctor's name** _____
**Signature** _____ **Date** ____/____/_____

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ONLY CHOICE URGENT CARE

**MEDICATION REFILL POLICY:**

**Refills for medication prescribed by your provider should be requested during your office visit. Request by phone will be addressed at our earliest convenience. Refills will not be approved after normal business hours, weekends or holidays. Therefore, please call in your refill request in a timely manner to us directly or for the pharmacy to contact our office.**

**Refills for controlled substances require an office visit. No exceptions will be made.**

**WE RESERVE AT LEAST 24 HOURS TO PROCESS ALL REFILL REQUEST.**

I ACKNOWLEDGE MEDICATION REFILL POLICY: _____

PATIENT SIGNATURE : DATE:

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

i acknowledge that the notice of Privacy Practices was availiable and that I read (or had the oportunity to read) and understand the notice.

Signature of Patient or Authotized Representative: _____

Signature Date

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## Patient History

**Have you ever been hospitalized?** (If there is not enough space provided, please continue on the other side of this form.)

**Date Hospital/Facility Reason**

___/___/____ _____ _____
___/___/____ _____ _____
___/___/____ _____ _____

- **Family History**

Father: Alive / Deceased Mother: Alive / Deceased
Brothers: Alive _____ Deceased _____ Sisters: Alive _____ Deceased _____
Sons: Alive _____ Deceased _____ Daughters: Alive _____ Deceased _____

- **Social History**

- Do You Smoke? Y N
If yes, how often? _____

- Have you smoked in the past? Y N
If yes, how often? _____

- Are you subject to second hand smoking? Y N
If yes, how often? _____

- Do you drink alcohol? Y N
If yes, how often? _____

- Do you do Recreational drugs? Y N
If yes, how often? _____

- Do you drink caffeine? Y N
If yes, how often? _____

- Do you exercise? Y N
If yes, how often? _____

**Please list any other information that may be helpful.**

_____
_____ **Name:**
_____ **Date** _____

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## REQUEST FOR RELEASE OF MEDICAL RECORDS

**DATE:** _____

**PATIENT:** _____

**DATE OF BIRTH:** _____

**SOCIAL SECURITY #:** _____

This request is to allow records (including any and all tests and reports)

To be released to DJ. Quality Care, LLC from

_____
(Name of doctor or hospital)

From any legal responsibility or liability for the release of information on the above patient

PATIENT'S SIGNATURE: _____

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## ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, you acknowledge that you have received/read the Notice of Privacy Practices of DJ. Quality Care, LLC.

Our Notice Practices explains how DJ Quality care, LLC may use and disclose you're protected health information for treatment, payment and healthcare options. Protected health information means your personal health information found in your medical and billing records.

Our Notice of Privacy Practices Information also contains additional general information regarding our practice operation and certain policy and procedures that may affect you.

**Your signature below acknowledges that you have received/read these notices.**

Patient Name: _____

Patient Signature: _____

Date: _____

Parent or Guardian Signature:

_____

Date: _____

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## Designation for Release of Medical Information to a Family Member, Friend or Legal Representative

**Introduction**

It is the physicians' responsibility to ensure that the physician-patient relationship is Confidential. The Privacy Statement of DJ Quality care, LLC is the basis for how we treat your Protected Health Information. HIPAA allows physicians to use their professional judgment on disclosing certain PHI to family, friends, etc. without an authorization. This form is an aid to the physicians in making a determination on disclosing such information. DJ Quality Care, LLC realizes there are times when you, the patient, may want another person to be knowledgeable about your medical condition or medical needs. Your doctor wants you to be able, if you so desire, to name a person (s) to whom you want the office staff to speak with about your medical condition. To enable that, we would ask that you complete the form listed below. Please note the following points:

- Only 3 people can be designated for this role
- The designation is valid until you cancel it in writing
- If you designate no one, DJ Quality Care, LLC may not be able to release information to any family member or friend.

**Designation Statement**

I, _____, designate the following person (s) to be able to speak to a physician at DJ Quality Care, LLC, a nurse or other staff member, should it be necessary, on my behalf. I hereby give permission to DJ Quality Care, LLC through its physicians and staff to release to my designee any information about my medical condition or medical needs or the status of my account and I release DJ Quality Care, LLC, its physicians and staff from any claim of confidentiality in connections with the release of this information.

Name of Designated Person: _____
Relationship: _____ Phone Number _____ (home/work)

Name of Designated Person: _____
Relationship: _____ Phone Number _____ (home/work)

Name of Designated Person: _____
Relationship: _____ Phone Number _____ (home/work)

Patient's Signature: _____
Date: _____ Witness: _____

**I decline to designate another person to speak with my physician or clinical staff.**

Patient's Signature: _____
Date: _____ Witness: _____