

# Patient Information

DOCTOR OF RECORD  
Tammie D Adams PA C

# AMC Urgent Care

PATIENT NAME (First Name, Middle Initial, Last Name)	PATIENT ID (Office Use Only)	DATE OF BIRTH	AGE	PRIMARY PHONE (HOME)	SECONDARY PHONE (WORK/CELL)
ADDRESS	SOCIAL SECURITY NUMBER	SEX (M or F) <input type="checkbox"/> M <input type="checkbox"/> F		MARITAL STATUS <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other	
CITY, STATE, ZIP	EMERGENCY CONTACT PERSON	RELATIONSHIP TO PATIENT		CONTACT PHONE	
EMPLOYER	OCCUPATION	PATIENT E-MAIL ADDRESS			
REFERRING DOCTOR NAME & ADDRESS					
PRIMARY CARE DOCTOR NAME & ADDRESS					

# Responsible Party

RESPONSIBLE PARTY NAME (First Name, Middle Initial, Last Name)				
ADDRESS		DATE OF BIRTH	SOCIAL SECURITY NUMBER	
CITY, STATE, ZIP		SEX (M or F)	PATIENT'S RELATION TO RESP	
EMPLOYER		OCCUPATION	RESP PARTY ID (Office Use Only)	

# Primary Insurance

WHO IS THE PRIMARY INSURED PARTY (CHECK ONE)

Patient (same as above)  Responsible Party (same as above)  Other (complete below)

INSURANCE COMPANY NAME	COPAY AMOUNT	INSURED'S NAME (First Name, Middle Initial, Last Name)		
INSURANCE COMPANY ADDRESS		INSURED'S ADDRESS, CITY, STATE, ZIP		
INSURANCE COMPANY CITY, STATE, ZIP		INSURED'S DATE OF BIRTH		
INSURANCE COMPANY PHONE NUMBERS		INSURED'S SOCIAL SECURITY NO.	INSURED'S SEX (M or F)	INSURED'S RELATION TO PATIENT
INSURED'S POLICY NUMBER	INSURED'S GROUP #	INSURED'S EMPLOYER		INSURED'S OCCUPATION

# Secondary Insurance

WHO IS THE SECONDARY INSURED PARTY (CHECK ONE)

Patient (same as above)  Responsible Party (same as above)  Other (complete below)

INSURANCE COMPANY NAME	INSURED'S NAME (First Name, Middle Initial, Last Name)			
INSURANCE COMPANY ADDRESS		INSURED'S ADDRESS, CITY, STATE, ZIP		
INSURANCE COMPANY CITY, STATE, ZIP		INSURED'S DATE OF BIRTH		
INSURANCE COMPANY PHONE NUMBERS		INSURED'S SOCIAL SECURITY NO.	INSURED'S SEX (M or F)	INSURED'S RELATION TO PATIENT
INSURED'S POLICY NUMBER	INSURED'S GROUP #	INSURED'S EMPLOYER		INSURED'S OCCUPATION

# Authorization and Acknowledgement

## Assignment of Benefits \* Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made to **AMC Urgent Care** and any assisting physicians, for the services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fee. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Date: \_\_\_\_\_ Your Signature: \_\_\_\_\_



**DATABASE TOOL**  
**Review of Systems**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

DOB: \_\_\_\_\_ Sex: M / F Race: \_\_\_\_\_

**For what reason are you here today?** \_\_\_\_\_

**Please check conditions you have experienced recently or that concern you:**

**GENERAL**

- good general health
- always tired
- always feel ill
- chronic fatigue
- loss of appetite
- wt loss >10 lbs
- wt gain >10 lbs
- unexplained fever >100°
- night sweats
- chills

**HEENT**

- eye pain
- eye drainage
- watery eyes
- itchy eyes
- spots in vision
- blurry vision
- double vision
- light flashes
- loss of vision
- ear pain
- ear drainage
- ear ringing
- hearing loss
- runny nose
- nasal congestion
- nose bleeds
- hay fever
- sinus pain
- frequent sinus infections
- frequent colds
- recent change in voice
- frequent sore throats
- hoarseness
- laryngitis
- swallowing pain

**HEART AND CIRCULATION**

- chest pain
- palpitations
- skipped heart beats
- extra heart beats
- fast heart beats
- high blood pressure
- calf pain / calf cramps
- ankle swelling
- blood clot in veins
- cold, purple feet

**RESPIRATORY**

- shortness of breath
- wheezing
- cough
- coughing blood
- snoring
- sleep apnea
- fluid in lungs

**GASTROINTESTINAL**

- persistent nausea
- unexplained vomiting
- frequent heartburn
- abdominal bloating
- swallowing difficulties
- abdominal cramps
- black stools
- bloody stools
- constant diarrhea
- constant constipation
- change in bowel habits
- bleeding from bowels
- anal / rectal pain
- hemorrhoids
- loss of bowel control
- require laxatives

**GENITOURINARY**

- painful urination
- trouble controlling urine
- urinate > 2 times at night
- blood in urine
- testicle lump / swelling
- penile discharge / sores
- irregular periods
- heavy periods
- no periods
- vaginal discharge / itching
- possibly pregnant
- pain with sex
- lack of sex drive
- no erection / orgasm

**MUSCULOSKELETAL / EXTREMITIES**

- joint : pain / stiffness
- general muscle aches
- pain: neck / back
- pain: hip / knee / foot
- pain: shoulder / elbow
- pain: wrist / hand

**SKIN / BREAST**

- unexplained rash
- change in skin color
- dry skin
- itching
- unusual or changed moles
- boils
- skin growths
- breast pain / lump
- nipple discharge

**NEUROLOGIC**

- frequent headaches
- blackouts / fainting
- dizzy or light headed
- poor balance
- difficulty walking
- tremors
- memory loss
- speech problems
- loss of strength
- seizures
- numbness

**PSYCHIATRIC**

- anxious
- depressed
- hyperactive
- attention deficit
- excess: fear / worry
- loss of interest in life
- suicidal thoughts
- unusual visions
- difficulty concentrating
- difficulty getting to sleep
- difficulty staying asleep
- impulsive

**ENDOCRINE**

- most always cold
- most always hot
- overweight
- abnormal hair growth
- hair loss
- change in skin color
- excess thirst
- excess urination
- changes in ring, hat, shoe size
- irregular menstrual cycles
- excessive sweating
- hot flashes

**LYMPHATIC / HEMATOLOGIC**

- blood transfusion
- free bleeder
- easy bruising
- lymph node swelling
- swollen extremity

**ALLERGIC / IMMUNOLOGIC**

- allergies to medicines
- allergies to cosmetics
- allergies to food
- hives
- hayfever

**INFECTIOUS DISEASE**

- contact with blood
- contact with body fluids
- recurrent skin infections
- recurrent sinus infections
- frequent foreign travel

**MISCELLANEOUS**

- chemical exposures
- toxic exposures
- radiation exposure
- occupational exposures
- sick pets
- drink well water
- drink unpasteurized milk
- process own meats

**OTHER**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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**DATABASE TOOL**  
**Medical and Personal History**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

DOB: \_\_\_\_\_ Sex: M / F Race: \_\_\_\_\_

**For what reason are you here today?** \_\_\_\_\_

**Please check conditions which you have had?**

**GENERAL**

- Serious Infections (e.g. pneumonia) \_\_\_\_\_
- Diabetes Mellitus
- Rheumatic Fever
- HIV Infection
- Cancer (where?) \_\_\_\_\_

**HEENT**

- Glaucoma
- Allergies "hay fever"
- Frequent Ear Infections
- Frequent Sinus Infections

**LYMPHATIC / HEMATOLOGIC**

- Thyroid Goiter
- Over Active Thyroid
- Under Active Thyroid
- Transfusions
- Anemia

- Kidney Stones
- Kidney Failure
- Prostate Disease
- Endometriosis
- Sex Transmitted Infection

**CVS**

- High Blood Pressure
- Congestive Heart Failure
- Heart Murmur
- Heart Valve Disease
- Angina
- Heart Attack
- High Cholesterol
- Abnormal Heart Rhythm
- Blood Clots in Veins
- Blocked Arteries in Neck
- Blocked Arteries in Legs

**RESPIRATORY**

- Asthma
- Emphysema
- Blood Clots in Lungs
- Sleep Apnea

**GI / GU**

- Stomach Ulcers
- Ulcerative Colitis
- Crohns Disease
- Bleeding from Intestines
- Diverticulitis
- Colon Polyps
- Irritable Bowel Disease
- Hepatitis
- Cirrhosis of the Liver
- Liver Failure
- Pancreatitis
- Gallstones

**SKIN / BREAST**

- Acne
- Eczema
- Psoriasis
- Fibrocystic Breast Disease

**MUSCULOSKELETAL / EXTREMITIES**

- Osteoporosis
- Rheumatoid Arthritis
- Degenerative Joint Disease
- Fibromyalgia
- Neck Pain (herniated disc)
- Back Pain (herniated disc)

**NEUROLOGIC / PSYCHIATRIC**

- Chronic Vertigo (Meniere's)
- Peripheral Nerve Disease
- Migraine Headaches
- Stroke
- Multiple Sclerosis
- Depression
- Anxiety

**Doctor's Notes:** \_\_\_\_\_

**Please indicate any surgeries you have had and the year you had them.**

- |                             |                            |                      |                     |
|-----------------------------|----------------------------|----------------------|---------------------|
| Year                        | Year                       | Year                 | Year                |
| ___ Angioplasty             | ___ Trauma Related Surgery | ___ Stomach Surgery  | ___ Tubal Ligation  |
| ___ Carotid Artery Surgery  | ___ Back or Neck Surgery   | ___ Inguinal Hernia  | ___ C-Section       |
| ___ Other Vascular Surgery  | ___ Hip Surgery            | ___ Colonoscopy      | ___ Hysterectomy    |
| ___ Coronary Bypass Surgery | ___ Knee Surgery           | ___ Gallbladder      | ___ Ovary Removed   |
| ___ Chest / Lung Surgery    | ___ Carpal Tunnel Surgery  | ___ Appendectomy     | ___ Breast Surgery  |
| ___ Tonsillectomy           | ___ Sinus Surgery          | ___ Prostate Surgery | ___ Thyroid Surgery |
| ___ Neurosurgery            | ___ Ear Surgery            | ___ Bladder Surgery  | ___ other _____     |

**Doctor's Notes:** \_\_\_\_\_

**Please indicate when you last had any of the following preventative tests or services.**

- |                       |                       |                                |                                |
|-----------------------|-----------------------|--------------------------------|--------------------------------|
| Year                  | Year                  | Year                           | Year                           |
| ___ Cardiac Angiogram | ___ Flu Vaccine       | ___ Prostate Cancer Blood Test | ___ Mammogram / Breast Exam    |
| ___ Stress Test       | ___ Pneumonia Vaccine | ___ Rectal Exam                | ___ Pap Smear                  |
| ___ Echocardiogram    | ___ Tetanus Vaccine   | ___ Colon Cancer Stool Test    | ___ Date of Last Physical Exam |
| ___ Chest X-ray       | ___ Hepatitis Vaccine | ___ Flexible Sigmoidoscopy     | ___ other _____                |
| ___ EKG               | ___ Bone Density Test | ___ Barium Enema               |                                |

**Doctor's Notes:** \_\_\_\_\_

Please list any allergies or intolerance to drugs or other substances.

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Please list the medications currently taken, their dosages, and how many times per day you take them.

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**FAMILY MEDICAL HISTORY**

Please check or list any major illness in your family members. (Mother, Father, Brothers, Sisters, or Children)

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Tuberculosis        | <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Breast Cancer   |
| <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Thyroid Disease   | <input type="checkbox"/> Epilepsy              | <input type="checkbox"/> Ovarian Cancer  |
| <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Anemia            | <input type="checkbox"/> Neurological Disorder | <input type="checkbox"/> Colon Cancer    |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hemophilia        | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Osteoporosis        | <input type="checkbox"/> _____             | <input type="checkbox"/> _____                 | <input type="checkbox"/> _____           |

Notes: \_\_\_\_\_

**PERSONAL INFORMATION**

Please write in or circle the information that applies to you:

Occupation:

Education	Sexuality	Marital Status	Living Status	Diet	Exercise	Alternative Medicine
primary	heterosexual	single	alone	none	none	holistic
secondary	homosexual	married	with spouse	low fat	walking	chiropractic
college	bisexual	divorced	with parents	low chol	aerobics	homeopathy
post grad	transsexual	widowed	assisted living	low carbo	weightlifting	acupuncture
doctorate		separated	nursing home	vegetarian	___ days / wk	herbal

**Tobacco**

never / past / active  
cigarette / cigar / pipe  
snuff / dip / chewing  
Start \_\_\_\_\_ Stop \_\_\_\_\_  
packs per day \_\_\_\_\_

**Alcohol**

never / past / active  
liquor / wine / beer  
\_\_\_ drinks per  
day / week / month  
AA / Alcohol Rehab

**Illicit Drugs**

never / past / active  
cocaine / marijuana  
heroin / amphetamine  
barbiturate / LSD / PCP  
IV Drug Abuse / Drug Rehab

**Caffeine**

never / past / active  
coffee / tea / soda  
\_\_\_ cans / cups per day

Doctor's Notes: \_\_\_\_\_

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Consent to the Use and Disclosure of Health Information  
for Treatment, Payment or Healthcare Operations\*\*

I understand as a part of my health and medical care, AMC Urgent Care Plus originates and maintains medical and health records describing my health history, symptoms, examination and test results diagnoses, treatment, and any plans for future care or treatment. I further understand this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who contributes to my care;
- a source of information for applying my diagnosis and treatment information to my bill;
- a means for a third-party payer to verify services were billed as actually provided;
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

**I further understand and agree this agreement to release information shall apply to all information accumulated up to this date and to any information acquired in the future. This agreement to release future information shall remain in force until such time as I shall revoke it in writing.**

I understand the patient has been provided with a PATIENT PRIVACY NOTICE which provides a more complete description of information uses and disclosures. I understand I have the right to review the PATIENT PRIVACY NOTICE prior to signing this consent. I understand this office reserves the right to change their signing this consent. I understand this office reserves the right to change their notice and practices. I understand I have the right to object to the use of my health information for directory purposes. I understand I have the right to request restrictions as to how my health information may be used or disclosed to carry our treatment, payment or healthcare operations and this office is not required to agree to the restrictions requested. I understand I must revoke this consent in writing, except to the extent the organizations has already taken action in reliance thereon.

By Oklahoma law we are required to notify you...the information authorized may include records which may indicate the presence of communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

Information may be released to the following individuals/organizations for the indicated purpose:

NAME:

RELATIONSHIP:

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I requested the following restrictions to the use and/or disclosure of my health information:

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You \_\_\_\_\_ may \_\_\_\_\_ may not leave (appointment, medical information etc.) on my message service or machine.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date Notice Effective

AMC Urgent Care \_\_\_\_\_ accepts \_\_\_\_\_ denies or \_\_\_\_\_ accepts conditionally... the restrictions imposed on release of information as stated above.

\_\_\_\_\_  
Signature/Title

\_\_\_\_\_  
Date

## Patient Acknowledgement Form

Patient Name:  
Patient DOB:  
Patient SSN:

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process claims submitted by the above named medical practice, clinic or provider. I also request payment of government benefits either to myself or to the party who accepts assignment below.

I further acknowledge that I have read a copy and that I understand the notice regarding the handling of my healthcare information.

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Signature of Patient or Authorized Person

Date

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Print Name of Person Signing Form

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits directly to the above named medical practice, clinic or provider.

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Signature of Insured or Authorized Person

Date

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Print Name of Person Signing Form