6260 El Camino Real, Suite 101
Carlsbad, CA 92009
760.448.6650

PATIENT INTAKE FORM – Coastal Family Urgent Care

PATIENT INFORMATION

Patient Name: _____ Sex: [ ] Male [ ] Female

Address: _____

City:_____ State: _____ Zip Code: _____

Date of Birth: _____ SS (For military insurances): _____

Phone Number: _____ Email: _____

Preferred pharmacy: _____ City: _____ Zip Code: _____

Preferred language: _____

EMERGENCY CONTACT

Emergency Contact Name: _____

Relationship: _____ Phone Number: _____

RESPONSIBLE PARTY (Must be parent or legal guardian for patients under the age of 18 years old) [ ] Self

Name: _____ Relationship: _____

[ ] **Same as above** Address: _____

City:_____ State: _____ Zip Code: _____

Date of Birth: _____ SS (For military insurances): _____

Phone Number: _____ Email: _____

INSURANCE INFORMATION

[ ] **Self Pay** [ ] **Health Insurance Provider**: _____

Healthcare Plan: _____ Member ID: _____

Reason for visit: _____

_____

How did you hear about us? [ ] Google [ ] Yelp [ ] Handout [ ] Friend [ ] Insurance Website

[ ] Referral [ ] School Fundraiser [ ] Other: _____

Please review carefully. Your initials indicate your acknowledgement and permission for the following:

_____ Authorization to leave voicemails on the phone number provided, which may contain personal medical information. This information may include, but is not limited to, demographic information (patient name, date of birth, address, etc.), billing information, and medical information (appointment dates, diagnosis, medications, test results, etc.).

_____ Authorization to send emails to the email address provided, which may contain personal medical information, if we are not able to do so through our patient portal. This information may include, but is not limited to, demographic information (patient name, date of birth, address, etc.), billing information, and medical information (appointment dates, diagnosis, medications, test results, etc.). Communications via email over the internet may not be secure. Although it is unlikely, there is a possibility information included in an email can be intercepted and read by other parties besides the person to whom it is addressed.

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_____ Authorization for Coastal Family Urgent Care to store your credit card information. No charges will be made without authorization.

_____ Authorization for Coastal Family Urgent Care to request and use the patient's prescription medication history from a third party for treatment purposes.

_____ Authorization for Coastal Family Urgent Care to release medical records to the patient's insurance carrier for billing purposes.

_____ You acknowledge, while we attempt to provide the most accurate information possible, eligibility and benefits differs with each patient's healthcare plan, and it is ultimately your responsibility to check with the patient's specific carrier to determine network status, coverage, and financial responsibility. Some services may be billed separately, and any amounts not paid by the patient's insurance company are your individual responsibility (examples include: Radiology readings, labs, and orthopedic supplies). Any co-payments or estimated co-insurance amounts determined by your insurance company's contract must be paid at time of service. If any of the services or charges are not covered by the patient's insurance company or if Coastal Family Urgent Care is not able to verify/confirm eligibility, you are responsible for all charges incurred.

_____ You understand Coastal Family Urgent Care will not assume responsibility for any personal property brought into the facility.

_____ If any healthcare worker is exposed to the patient's blood or other bodily fluid, Coastal Family Urgent Care can test the patient's blood for diseases including, but not limited to, hepatitis, HIV, and syphilis.

_____ San Diego County and California public health officials have issued orders to prevent the spread of COVID-19. You acknowledge you are aware of the health orders in effect issued by the San Diego Public Health Department regarding **isolation measures for COVID-19 positive** patients and **quarantine of people exposed** to COVID-19. These orders may be found at:
https://www.sandiegocounty.gov/content/sdc/hhsa/programs/phs/community_epidemiology/dc/2019-nCoV/health-order.html

Prior to completing this section, please review our TERMS OF USE, NOTICE OF PRIVACY PRACTICES and PATIENT RIGHTS AND RESPONSIBILITIES. These forms can also be found on our website at www.coastalfamilyuc.com/forms. A copy may also be provided upon request.

After review, please initial the following:

_____ I have reviewed, acknowledge and accept the terms in the NOTICE OF PRIVACY PRACTICES.

_____ I have reviewed, acknowledge and accept the terms in the PATIENT RIGHTS AND RESPONSIBILITIES.

_____ I have reviewed, acknowledge and accept the terms in the TERMS OF USE.

By signing below, you as the patient or authorized representative, consent for Coastal Family Urgent Care to provide health care services for the patient named above, and acknowledge, understand, and accept the terms stated.

_____ _____
Patient/Authorized Representative Name Date

_____
Patient/ Authorized Representative Signature