

Mission Medical Urgent Care
26800 Crown Valley Pkwy, Suite 150
Mission Viejo, CA 92691

Peter C. Czuleger, M.D.

Woodrow P. Wilson M.D.

Patient Information – Please Print:

Patient Legal Last Name: _____ First Name: _____ Middle _____

Address: _____ City _____ State: _____ Zip Code: _____

Home Phone:(____) _____ Cell Phone:(____) _____ Spouse Phone:(____) _____ DOB: _____

M/F (circle one) Age: _____ SMWD SS# _____ DL# _____ Exp: _____ State _____

Occupation: _____ Employer: _____

Address: _____ How Long?: _____ Phone Number:(____) _____

Spouse or (Responsible Party) Name: _____ DOB _____ SS# _____ DL# _____

Address: _____ City _____ State _____ Zip Code: _____

Employer Name and Adress: _____

Employer Phone#(____) _____ Home Phone(if different) _____ Occupation: _____ How Long? _____

PLEASE LIST OTHER FAMILY MEMBERS SEEN HERE: _____

In case of emergency, who should we contact? _____ Phone#:(____) _____ Relationship _____

Primary Insurance Information:

Insurance Name: _____ Insurance Phone#(____) _____

Billing Address: _____

Insured Subscriber's Name: _____

Relationship of Patient to Insured/Subscriber: Self Father Mother Child Other

ID# _____ Group# _____ Effective Date: _____

CO-PAY:\$ _____ CO-PAYMENTS ARE DUE AT THE TIME OF CHECK-IN

Work Related: YES/NO AUTO: YES/NO DATE OF INJURY: _____

WE REQUIRE A COPY OF YOUR INSURANCE CARD AND DRIVERS LICENSE AT THE TIME OF VISIT

AUTHORIZATION OF TREATMENT AND ASSIGNED BENEFITS: I hereby authorize Mission Medical Urgent Care to perform such medical services, which in their medical judgment are necessary for the welfare of the patient identified above. I authorize them to furnish information to insurance carriers concerning this illness and/or injury. I hereby irrevocably assign all benefits, including major medical benefits, for medical services rendered to be paid directly to the doctor in accordance with California Insurance Code, Section 10133. 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 company.

SUBSCRIBER/INSURED SIGNATURE: _____ DATE: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGMENT FORM: I have reviewed and or received a copy of

Mission Medical Urgent Care's notice of Privacy Practices

Signature of Patient or Guardian: _____ Relationship: _____ Date: _____

HEALTH HISTORY

(Confidential)

Name: _____ Today's Date: _____
 Age: _____ Birthdate: _____ Date of last physical examination: _____
 What is your reason for visit? _____

SYMPTOMS YOU CURRENTLY HAVE OR HAVE HAD IN THE LAST YEAR

<p><u>GENERAL</u></p> <input type="checkbox"/> Chills <input type="checkbox"/> Depression <input type="checkbox"/> Dizziness <input type="checkbox"/> Diabetes <input type="checkbox"/> Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headache <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Loss of weight <input type="checkbox"/> Nervousness <input type="checkbox"/> Numbness <input type="checkbox"/> Sweats	<p><u>GASTROINTESTINAL</u></p> <input type="checkbox"/> Appetite poor <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Stomach pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood	<p><u>EYE, EAR, NOSE, THROAT</u></p> <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Blurred vision <input type="checkbox"/> Crossed eyes <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Double vision <input type="checkbox"/> Earache <input type="checkbox"/> Ear discharge <input type="checkbox"/> Hay fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Persistent cough <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems <input type="checkbox"/> Vision - Flashes <input type="checkbox"/> Vision - Halos	<p><u>MEN only</u></p> <input type="checkbox"/> Breast lump <input type="checkbox"/> Erection difficulties <input type="checkbox"/> Lump in testicles <input type="checkbox"/> Penis discharge <input type="checkbox"/> Sore on penis <input type="checkbox"/> Other _____
<p><u>MUSCLE/JOINT/BONE</u></p> <p>Pain, weakness, numbness in:</p> <input type="checkbox"/> Arms <input type="checkbox"/> Hips <input type="checkbox"/> Back <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Neck <input type="checkbox"/> Hands <input type="checkbox"/> Shoulders	<p><u>CARDIOVASCULAR</u></p> <input type="checkbox"/> Chest pain <input type="checkbox"/> High blood pressure <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Varicose veins	<p><u>SKIN</u></p> <input type="checkbox"/> Bruise easily <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Change in moles <input type="checkbox"/> Rash <input type="checkbox"/> Scars <input type="checkbox"/> Soar that won't heal	<p><u>WOMEN only</u></p> <input type="checkbox"/> Abnormal Pap Smear <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Breast lump <input type="checkbox"/> Extreme menstrual pain <input type="checkbox"/> Hot flashes <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Other _____
<p><u>GENITO-URINARY</u></p> <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Painful urination			<p>Date of last menstrual period: _____</p> <p>Date of last Pap Smear: _____</p> <p>Have you had a mammogram? _____</p> <p>Are you Pregnant? _____</p> <p>Number of children _____</p>

CONDITIONS YOU HAVE HAD IN THE PAST (CURRENTLY HAVE - DOUBLE MARK ✓✓)

<input type="checkbox"/> AIDS <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anemia <input type="checkbox"/> Anorexia <input type="checkbox"/> Appendicitis <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Breast Lump <input type="checkbox"/> Bronchitis <input type="checkbox"/> Bulimia <input type="checkbox"/> Cancer <input type="checkbox"/> Cataracts	<input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Diabetes <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Glaucoma <input type="checkbox"/> Goiter <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Gout <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hernia <input type="checkbox"/> Herpes	<input type="checkbox"/> High Cholesterol <input type="checkbox"/> HIV Positive <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Measles <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Miscarriage <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Mumps <input type="checkbox"/> Pacemaker <input type="checkbox"/> Pneumonia <input type="checkbox"/> Polio	<input type="checkbox"/> Prostate problem <input type="checkbox"/> Psychiatric Care <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Stroke <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Typhoid Problems <input type="checkbox"/> Ulcers <input type="checkbox"/> Vaginal Infections <input type="checkbox"/> Venereal Disease
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MEDICATIONS YOU ARE CURRENTLY TAKING

ALLERGIES TO MEDICATIONS

Pharmacy Name: _____	Phone: _____

MISSION MEDICAL URGENT CARE

26800 CROWN VALLEY PKWY. STE 150, MISSION VIEJO, CA 92691

(949) 276-2111

FAX: (949) 276-2115

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CLIENT AGREEMENT

OUR ASSISTANCE WITH INSURANCE BILLING IS A COURTESY AND DOES NOT RELIEVE YOU OF THE OBLIGATION FOR PAYMENT OF YOUR ACCOUNT.

IT IS THE RESPONSIBILITY OF THE PATIENT OR RESPONSIBLE PARTY TO INSURE THAT ALL DEDUCTIBLES AND CO-PAYMENTS ARE PAID.

PLEASE UNDERSTAND THAT IF YOUR INSURANCE COMPANY DOES NOT PAY FOR SERVICES PROVIDED BY MISSION MEDICAL URGENT CARE, YOU ARE RESPONSIBLE FOR PAYMENT OF THE TOTAL FEE.

I ACKNOWLEDGE THAT I HAVE READ THE ABOVE AND AGREE TO PAY FEES NOT PAID BY MY INSURANCE COMPANY FOR ALL SERVICES RENDERED.

PATIENT OR RESPONSIBLE PARTY

DATE

THIS FORM IS NEEDED TO SUBMIT TO YOUR INSURANCE COMPANY,
WHETHER OR NOT YOUR SYMPTOMS ARE DUE TO AN ACCIDENT OR
SPECIFIC INJURY, BECAUSE YOU ARE SEEING A PHYSICIAN AT THIS TIME.

RELEASE FORM

PATIENT NAME: _____

REASON FOR VISIT: _____

ONSET OF SYMPTOMS/DATE OF ACCIDENT OR INJURY: _____

LOCATION INJURY OCCURRED: _____

HOW IT HAPPENED: _____

**RESPONSIBLE PARTY INFORMATION-(IF DIFFERENT FROM
PATIENT'S HEALTH INSURANCE):EXAMPLE- PATIENT'S AUTO
INSURANCE**

NAME OF INSURANCE COMPANY: _____

INSURED NAME: _____ CLAIM# _____

INSURANCE BILLING
ADDRESS: _____

AGENT'S NAME: _____ COVERAGE AMOUNT:\$ _____

PHONE: _____ FAX: _____

I hereby authorize Mission Medical Urgent Care, to release this information to my insurance company and all other information pertaining to this accident/injury/ or onset of symptoms in order to process my claim(s) involving the above event. I authorize benefits payable to Mission Medical Urgent Care, from my insurance company covering the above event. I acknowledge that any balance owed will be paid in full by myself/insured upon request of such balance, either in writing or in person.

SIGNED: _____ **DATE:** _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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I understand that, under the Health Insurance Portability & Accountability Act of 1966 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare provider who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physical certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I can contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature on acknowledgement of this *Notice of Privacy Practices Acknowledgement*, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____