Temecula 24 Hour Urgent Care
We're here when you need us.
41715 Winchester Road Ste. 101
Temecula, CA 92590
Ph: 951.308.4451 | Fax: 951.506.0992

Carlsbad Urgent Care
We're here when you need us.
2804 Roosevelt Street
Carlsbad, CA 92008
Ph: 760.720.2804 | Fax: 760.720.7400

Carlsbad Urgent Care San Marcos
We're here when you need us.
295 S. Rancho Santa Fe Road
San Marcos, CA 92078
Ph: 760.471.1111 | Fax: 760.471.1001

PATIENT INFORMATION FORM

INFORMATION TO BE FILLED OUT COMPLETELY

PATIENT NAME: _____ (Last Name) , _____ (First Name) SEX: ◯ MALE ◯ FEMALE

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

ADDRESS: _____ APT.#: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE #: _____ CELL PHONE #: _____

MARITAL STATUS: ◯ SINGLE ◯ MARRIED ◯ DIVORCED ◯ WIDOWED

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

EMERGENCY CONTACT DATE OF BIRTH: _____ CONTACT'S PHONE #: _____

INSURANCE INFORMATION *or* SELF-PAY *(No Insurance)*

PRIMARY INSURANCE:

CHECK ONE: ◯ SELF-PAY *(No Insurance)* ◯ PPO ◯ HMO ◯ POS ◯ EPO

If Insured, complete the following questions:

◯ I, the Patient, ***AM*** the Primary Subscriber for this Insurance.

◯ I am ***NOT*** the Primary Subscriber for this Insurance.

If ***NOT*** the Primary, the Primary Subscriber's Name is: _____

Relationship to Primary Subscriber: _____ Primary Subscriber's SSN: _____

Primary Subscriber's Date of Birth: _____ Primary Subscriber's Phone: _____

Primary Subscriber's Address: _____

CITY: _____ STATE: _____ ZIP: _____

SECONDARY INSURANCE:

CHECK ONE: ◯ PPO ◯ HMO ◯ POS ◯ EPO

◯ I, the Patient, ***AM*** the Primary Subscriber for this Insurance.

◯ I am ***NOT*** the Primary Subscriber for this Insurance.

If ***NOT*** the Primary, the Primary Subscriber's Name is: _____

Relationship to Primary Subscriber: _____ Primary Subscriber's SSN: _____

Primary Subscriber's Date of Birth: _____ Primary Subscriber's Phone: _____

Primary Subscriber's Address: _____

CITY: _____ STATE: _____ ZIP: _____

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Authorization / Consent

- I hereby consent to and authorize the administration of all diagnostic and therapeutic treatments that may be considered advisable or necessary in the judgment of the medical provider.
- I hereby authorize the medical provider to release any information acquired in the course of my examination or treatment as needed for payments or authorizations for tests, procedures, referrals or any other services deemed medically necessary.
- I hereby authorize payment directly to the medical provider, of benefits otherwise payable to me, for service rendered.

PRINT NAME *(Patient or Guardian)*: _____ Relationship to Patient: _____

SIGNATURE (*Patient or Guardian)*: _____ DATE: _____

Authorization to Release Medical Information

Release Records To:

Name: _____ Phone: _____ Fax: _____

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

HIPAA AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION:
I voluntarily authorize the above Releasing Entity to use and disclose my health information.

PRINT NAME *(Patient or Guardian)*:: _____ Relationship to Patient: _____

SIGNATURE (*Patient or Guardian)*: _____ DATE: _____

Please initial the following spaces if you have read and understand the following policies and have reviewed copies of these policies:

_____ Member Eligibility / Covered California Waiver

_____ Financial Policy

_____ HMO / Self-Pay Waiver

Carlsbad San Marcos Temecula 24 Hour Urgent Cares
We're here when you need us.

Which Clinic are you visiting today?

◯ Temecula 24 Hr. Urgent Care
◯ Carlsbad Urgent Care
◯ Carlsbad Urgent Care – San Marcos

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MEDICAL QUESTIONNAIRE

INFORMATION TO BE FILLED OUT COMPLETELY

PATIENT NAME: _____ , _____ SEX: ◯ MALE ◯ FEMALE
Last Name *First Name*

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

REASON FOR TODAY'S VISIT: _____

Duration of Symptoms: _____ Is this potentially a Medical Legal Claim? ◯ YES ◯ NO Is this a work related injury? ◯ YES ◯ NO

NOTE: **If you are here *ONLY* for a Department of Transportation drug or alcohol screening, the section below is optional.**

YES	NO		YES	NO		YES	NO	
◯	◯	CHEST PAIN / PRESSURE	◯	◯	FAINTING SPELLS / LOSS OF CONSCIOUSNESS	◯	◯	DIFFICULTY BREATHING
◯	◯	PAINFUL URINATION	◯	◯	COUGH	◯	◯	FREQUENT URINATION
◯	◯	HEAD INJURY	◯	◯	FEVER	◯	◯	CHANGE IN URINE COLOR
◯	◯	RASH	◯	◯	UNINTENDED WEIGHT LOSS / GAIN *(20 lbs. in 6 months)*	◯	◯	CHRONIC or RECURRENT BACK PAIN
◯	◯	EYE PAIN	◯	◯	IRREGULAR HEARTBEAT	◯	◯	PAIN IN JOINTS
◯	◯	BLURRY VISION	◯	◯	ABDOMINAL PAIN	◯	◯	MUSCLE PAIN
◯	◯	DOUBLE VISION	◯	◯	HEARTBURN / GERD	◯	◯	MUSCLE WEAKNESS
◯	◯	EAR PAIN / EAR PRESSURE	◯	◯	NAUSEA	◯	◯	HEADACHE
◯	◯	RECENT DECREASED HEARING	◯	◯	VOMITING	◯	◯	LIGHTHEADEDNESS
◯	◯	LOSS OF APPETITE	◯	◯	DIARRHEA	◯	◯	DIZZINESS
◯	◯	PAINFUL BREATHING	◯	◯	CONSTIPATION	◯	◯	NUMBNESS / TINGLING
◯	◯	ABNORMAL BREATHING SOUNDS / WHEEZING	◯	◯	BLOODY or BLACK STOOL	◯	◯	EXCESSIVE THIRST & URINATION

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VERIFICATION OF BENEFITS CHECKLIST

- ☐ Call **MEMBER SERVICES** (This phone number located on ***back*** of insurance card)
- ☐ Provide your **NAME**, **DATE OF BIRTH**, **MEMBER ID**, and **GROUP NUMBER** to the **MEMBER SERVICES** representative. (The Member and Group ID Numbers are located on ***front*** of insurance card)
- ☐ Verify the clinic you are going to visit is **IN-NETWORK** (If not **IN-NETWORK**, ask about your **OUT-OF-NETWORK BENEFITS**.)
- ☐ Ask about your **CO-PAY**, **CO-INSURANCE**, and **DEDUCTIBLE**.
- ☐ Have **MEMBER SERVICES** immediately fax the **ELIGIBILITY AND BENEFITS REPORT** to the clinic you are seeking care and treatment:

TEMECULA:	**951-506-0992**
CARLSBAD:	**760-720-7400**
SAN MARCOS:	**760-471-1001**

- ☐ Obtain a **REFERENCE NUMBER** regarding your call for your documentation and records.

Example of Insurance Card: