GENESIS MEDICAL GROUP/PARKWAY URGENT CARE

100 North Green Valley Parkway, Suite 110
Henderson, Nevada 89074
Phone (702) 436-7700 Fax (702) 436- 3800

Last Name ________________________ **First Name** _________________________________**Middle Initial** _________

Address ____DON'T USE PO BOX #

City ______________________________________State ____________________Zip _____________________________

Home Phone ________________________Work Phone __________________________Cellular ___________________

DOB ____________________Age ________Sex ________Marital Status M S W D

Social Security _________________________Employer _______________________Occupation __________________

Preferred Language: ☐ English ☐ Spanish ☐ Other ____

Race: ☐ African American ☐ American Indian ☐ Asian/Pacific Islander ☐ Alaska Native ☐Asian ☐Hawaiian ☐Caucasian

☐ Pacific Islander ☐ Black or African American ☐Refused to report ☐ Other________________________

Ethnicity: ☐ Hispanic/Latino ☐Non Hispanic Latino ☐Refused to report

Guarantor's Name ____Date of Birth _____________________

Guarantor's Employer ____Social Security _______________________

Emergency Contact #_____________________Relationship ____

Primary Insurance ________________________________Secondary Insurance __________________________________

Policy Holder Name ____________________ ________Policy Holder Name _____________________________________

Policy Holder DOB ____________________________________Policy Holder DOB ________________________________

Policy Holder Social Security _________________________Policy Holder Social Security _________________________

Policy Holder Employer ______________________________Policy Holder Employer _______________________________

If you currently have **Medicare** or have had Medicare in the past you must answer the following:

Are you with any Senior Advantage Plan or HMO's? __________ ________ Initial

Do you plan to move to an HMO or Senior Plan? __________ ________ Initial

Do you have the traditional Medicare Coverage? __________ ________ Initial

●●

________1) I understand that I am responsible for charges not covered or reimbursed by the above agents, I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required). In the event that an Insurance Company denies consideration of a claim due to a motor vehicle accident, I agree to pay any and all balances in full related to that claim
Initial

_________2) I authorize my insurance carrier to release information regarding my coverage to Genesis Medical Group. I also authorize agents of any hospital, treatment center or previous physicians to furnish Genesis Medical Group copies of any records of m y medical history, services or treatments. I also authorize the release of any medical information and /or reports related to my treatment to any federal, state or accreditation agency, or any physician or insurance carrier as needed. I also agree to a review of my records for purposes of internal audits, research and quality assurance reviews within Genesis Medical Group.
Initial

_________3) My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to Genesis Medical Group. This assignment covers any and all benefits under Medicare .other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services . In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative , I will endorse such payments.
Initial

_________4) I understand that I have the right to request and receive a Notice of Privacy Information from Genesis Medical Group
Initial

I have read the above statements and accept the terms. If requested, a copy of the statements is considered the same as the original.

_____ _____ _____

Patient/Responsible Party Signature Relationship Date

PATIENT MEDICAL HISTORY

Reason for visit _____

The following information is very important to your health. Please take the time to fully and accurately fill out this form.

Referred by _____ Today's Date _____

Patient Name _____DOB _____ AGE _____ SEX _____

Have you ever been diagnosed with any of the following?

☐ High Blood Pressure	☐ Diabetes Mellitus (sugar)	☐ Angina Pectoris	☐ Heart Attack
☐ High Cholesterol	☐ Blood clots	☐ Stroke	☐ Emphysema
☐ Asthma	☐ Hepatitis	☐ Hypothyroidism	☐ Arthritis
☐ Cancer	☐ Anemia (low blood count)	☐ Kidney Stone	☐ Rheumatic Fever
☐ Ulcers (Bleeding)	☐ Cataract	☐ Irregular Heart Beats	☐ Tuberculosis
☐ Hypertension	☐ Convulsions	☐ Frequent Headaches	☐ Liver Disease

Do you have any drug allergies? _____

Do you use tobacco: ☐ Yes ☐ No If yes how long? _____How many packs a day? _____

☐ Current everyday smoker ☐ Current some day smoker ☐ Former smoker ☐ Smoker ☐ current status unknown

☐ Unknown if ever smoker ☐ When did you stop smoking _____

Please list all medications you are currently taking:

_____

_____

_____

Significant Past Family History:

_____

_____

_____

PAST SURGICAL HISTORY

☐ Appendectomy Year _____ ☐ Cataract Laser Year _____ ☐ Tonsillectomy Year _____

☐ Hemorrhoidectomy Year _____ ☐ Gallbladder Removal Year _____ ☐ Hernia Repair Year _____

☐ Hysterectomy Year _____ ☐ Colonoscopy/Sigmoidoscopy Year_____ ☐ Bypass Surgery Year _____

Others, please specify: _____