MedStar Health

EMERGENCY SCREENING

Welcome to MedStar Health Urgent Care. To provide the very best care for you and protect your privacy, we ask that you complete this form immediately and provide it to the front desk associate at the reception desk.

Patient Name: _____ Date of Birth: _____

Phone Number: _____ Primary Care Clinician or Practice: _____

REASON FOR YOUR VISIT TODAY: _____

Is today's visit related to work place injury? ❑ Yes ❑ No

Is today's visit related to an auto accident? ❑ Yes ❑ No

Have you (or the patient) traveled recently? ❑ Yes ❑ No If yes: **Date: _____ Location: _____**

IF YOU (OR THE PATIENT) ARE EXPERIENCING ANY OF THE FOLLOWING AT THIS TIME PLEASE CIRCLE THE SYMPTOM/EVENT:

1. **Chest pain** (not associated with coughing or flu symptoms), pressure or heaviness in the chest, chest pain that radiates into the shoulder, arm, back or jaw, heart attack
2. Difficulty breathing, **shortness of breath**, asthma attack
3. Severe or uncontrolled **bleeding**
4. Loss of consciousness, **fainting** or **seizure**
5. Foreign object in the **eye** or chemicals splashed in the eye
6. Medication **overdose** or ingestion of a chemical
7. Sudden onset of one-sided extremity or facial weakness, difficulty speaking, blurred vision, dizziness, headache, confusion, disorientation or other symptoms of a **stroke**
8. Possible contagious **rash** (such as chickenpox, scabies, measles)
9. Fall, injury or motor vehicle crash with neck pain, headache, **head injury**, numbness, weakness or tingling in the extremities
10. Severe **abdominal pain**, testicular pain or pregnancy with severe abdominal pain

Staff Reviewed
Initials: _____
Time: _____
Placed in Mask
Y or N (circle)

Please wear a mask for fever, chills, cough, rash, body aches, runny nose, red eyes, sore throat, sensitivity to light, neck stiffness, headache or swollen cheeks face or neck.

_____

_____ _____ _____

Signature Date Time

_____ _____

Name of Representative Signing for Patient Relationship of Representative to Patient

(Required if the patient is a minor or an adult unable to sign this form)

STAFF USE ONLY IF NEEDED IN AN EMERGENCY

Vital Signs: BP: ____/_____ Height: _____cm Weight: _____kg Pain: _____

Temp: _____C Pulse: _____ Resp: _____ SpO2:_____% Time: _____ Initials: _____

Address:_____ Employment Status:_____ Marital Status: _____

Emergency Contact Name: _____ Phone Number: _____ Relationship: _____

Who is the Policy Holder of the Insurance: _____ DOB of Policy Holder: _____

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AUTOMOBILE OR WORK INJURY

Please complete this form if the reason for today's care is an automobile accident or an injury at work **and** this is the first time you are being seen by MedStar Heath Urgent Care for this particular injury.

PATIENT - ACCIDENT INFORMATION

Patient Name:_____ Today's Date: _____

Social Security Number:_____ Date of Accident: _____

State Where Accident Occurred: _____

INSURANCE INFORMATION

Insurance Company Name: _____

Employer Name (work injury only):_____

Employer Address:_____

Claim Number: _____

Contact/Adjuster Name:_____ Phone Number: _____

Billing Address: _____

_____

The information on this form is correct to the best of my knowledge.

Signature:_____ Date: _____

MedStar Health

MEDSTAR HEALTH URGENT CARE
NEW PATIENT HISTORY FORM

Patient's Full Name: _____ **Date of Birth:** _____

PHARMACY: Please Provide Your Pharmacy Information So We Can Send Prescriptions Electronically to the Pharmacy

Pharmacy Name: _____ **Phone No.:** _____

Pharmacy Address: _____

MEDICAL, FAMILY, SOCIAL HISTORY:

Medication-Drug Allergies: _____

Current Medications: _____

Have You Been Diagnosed With Any of the Following (*Check All That Apply*):

- ❑ Heart Disease
- ❑ Anxiety Or Depression
- ❑ Asthma Or COPD/Emphysema
- ❑ Diabetes
- ❑ Cancer: (*Type*) _____
- ❑ Gastrointestinal (GI) Bleeding
- ❑ High Blood Pressure (Hypertension)
- ❑ Seizure Disorder
- ❑ Stroke

Any Other Medical History: _____

Any History of Surgery: _____

Family History – Parent/Sibling (*Check All That Apply*): ❑ Cancer ❑ Heart Disease ❑ Diabetes Mellitus ❑ Hypertension

For Females (of Childbearing Age): Last Menstrual Period: _____ **Birth Control** ❑ Yes ❑ No (*Type*) _____

For Children: Is Your Child Up to Date on Vaccinations? ❑ No ❑ Yes

Tobacco Use: ❑ No ❑ Yes **Alcohol Use:** ❑ Never ❑ Rarely ❑ Occasional ❑ Heavy

Completed By: ❑ Patient ❑ Parent/Guardian/Other **Signature:** _____

Print Name Here if Parent/Guardian/Other: _____

MedStar Health

Consent to Treat a Minor

To Parents and Guardians of Minor Children:

The providers and staff of MedStar Health place great emphasis on the health and well-being of each and every patient in our clinic. We appreciate that you have entrusted us to provide health care services to your minor child and we look forward to working with you to ensure that your child receives the best health care possible.

As a general rule, we require the consent of a **parent or legal guardian** in order to provide health care services to a minor child (someone under the age of 18). If your minor child presents to the clinic unaccompanied, we will not be able to see the unaccompanied minor. If the minor presents in the company of an adult other than a parent or legal guardian, they must have documentation from the parent or legal guardian giving consent for treatment. If they do not have consent for treatment the appointment will be rescheduled.

In an effort to provide the care needed and avoid having to reschedule your child's appointment, we have developed a ***Consent to Treat a Minor*** form that, once completed by a parent or legal guardian, will be placed in your child's medical record for use as necessary. This form will allow us to provide routine and emergency medical treatment for your minor child when deemed necessary by qualified medical personnel. Adults, other than the parent or legal guardian who accompany a minor child to an appointment and are authorized by the Consent to Treat a Minor on record, will be asked to present photo ID upon checking the patient in for the appointment. This consent form will remain in effect until revoked in writing. You may request this form from any member of our clinic staff.

By law, minors have the right to consent to certain health care without a parent or guardian's consent. A minor may consent to medical:

- If the minor is emancipated (legally independent), married or is parent of a child
- For birth control and pregnancy-related care
- For sexually transmitted diseases, including HIV
- In the event emergency care is necessary
- For outpatient drug and alcohol abuse related treatment
- For outpatient mental health treatment beginning at age 16

If a minor consents to care as allowed by law, he or she can request confidentiality for that aspect of care which would prohibit us from releasing this information to anyone, including a parent or guardian, without the minor's express written permission.

It is the philosophy of this clinic to encourage minor patients to include a parent, guardian or other trusted adult in all aspects of their health care including those areas noted above. For legal and other reasons, parent or guardian involvement may not always be possible. Rest assured that we would continue to provide health care services that are in the best interests of your minor child.
If you have questions regarding any of this information, please contact your child's primary care physician.

MedStar Health

Consent to Treat a Minor

Patient name: _____ Date of birth:__ /__ /__

I, the undersigned, parent(s) or legal guardian of the above named patient, a minor, do hereby authorize the physicians at MedStar Health to act as agent(s) for the undersigned to consent to physical examination, medical diagnosis and treatment or other medical care which is deemed advisable by, and is to be rendered under the general or special supervision of, the treating physician who is licensed to practice in the state of Maryland, whether such diagnosis or treatment is rendered at the office of said physician or at any hospital. I further acknowledge that I am responsible for any portion of charges that are not covered by the child's insurance.

In an emergency, it is understood that authorization is granted to the physicians at MedStar Health in advance of any specific diagnosis, treatment or hospital care rendered to the above named patient. Authorization is granted to provide authority and power on the part of the physicians to provide all such medical or surgical diagnosis, treatment or hospital care which the aforementioned physician(s), in the exercise of his or her best judgment, may deem advisable.

Consent to Treat a Minor Child accompanied by an adult other than the child's parent or legal guardian

I, the parent or legal guardian of the patient named above, do hereby authorize the physicians at MedStar Health to perform medical treatment as per the statements above when accompanied by either of the following named adult persons over the age of 18:

Adult's name: _____ Relationship to the child: _____
(Print Name) (Grandparent, Aunt, Uncle, Sister, Brother, Family Friend)

Adult's name: _____ Relationship to the child: _____
(Print Name) (Grandparent, Aunt, Uncle, Sister, Brother, Family Friend)

This authorization is valid:

☐ For any and all medical treatment including preventative care, school/sports physicals & vaccines.

☐ Today's visit only ____ /___ /____

☐ For this specific problem(s) or a specific date range. Please specify _____

- **This consent will be valid until revoked in writing by me from the date signed unless otherwise specified in writing.**

Parent or legal guardian: (Print Name) _____ Date: ___ / ___ / ___

Parent or legal guardian signature: _____

Witness: (Print Name)_____ Signature: _____

MedStar Health

Oral consent given by parent over the phone. Acknowledge by two MedStar Health Associates.

MedStar Health Associate Witness: _____ Date___/___/___

MedStar Health Associate Witness: _____ Date___/___/___