Cares Clinic

Patient Information and Consent

Please Print

Patient Name

Legal First Name | Legal Last Name | Suffix | Preferred First Name

Permanent Address | Apt. # | City | State | Zip

Phone # | Social Security # | Gender | Birth Date

Email _____

(We will never rent or sell your email address – we value your privacy.)

No Email ☐

Medical Insurance? No ☐ Yes ☐

Medical Insurance Information

Insurance Company | Policy Holder's Name | Policy Holder's Relationship to Patient

Policy Holder's Address | City | State | Zip

Policy Holder's Birth Date | Policy Holder's Social Security # | Employer

PATIENT DEMOGRAPHIC

Language | Marital Status

Race: ☐ African American ☐ American Indian/Alaska Native ☐ Asian ☐ Hispanic ☐ Mixed Race ☐ White ☐ Other ☐ Refuse to Report

Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Refuse to Report

Emergency Contact Information

Contact Name _____ Phone # _____ Relationship to Patient _____

Pharmacy

I would like to use ICM Cares recommended pharmacy (Germantown Walmart): Yes ☐ No ☐

If not, please provide:

Preferred Pharmacy _____

Address of Pharmacy _____

I give ICM Cares Clinic permission to write prescriptions on my behalf. Yes ☐ No ☐

Patient Employment Information

Employer Name

Not employed ☐

Consent for Treatment

I voluntarily consent to any and all health care treatment and diagnostic procedures provided by ICM Cares Clinic and its associated physicians, clinicians, and other personnel. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations at ICM Cares Clinic.

Patient or Authorized Person's Name | Signature | Date

I consent to receive SMS text reminders for appointments from ICM Cares Clinic.

Patient or Authorized Person's Name | Signature | Date

Cares Clinic

Patient Medical History

Allergies

If you have no known allergies, please check the box at right. ☐ No known allergies to report

1. Medication: _____ Reaction: _____
2. Medication: _____ Reaction: _____

Major Illnesses (please check all that apply)

Hypertension:	☐ Current	☐ Past	☐ N/A	Notes: _____
Diabetes:	☐ Current	☐ Past	☐ N/A	Notes: _____
Cancer:	☐ Current	☐ Past	☐ N/A	Notes: _____
Other:	☐ Current	☐ Past	☐ N/A	Notes: _____

Surgeries (please list all major surgeries with estimated dates)

If you have never had any major surgeries, please check the box at right. ☐ No surgeries to report

_____

_____

Family History

Mother:	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Father:	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Brother:	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Sister:	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Grandmother (M):	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Grandmother (P):	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Grandfather (M):	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Grandfather (P):	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A

Social History

Drink alcohol:	☐ Currently	☐ In the past	☐ Never	How much and how often? _____
Use tobacco products:	☐ Currently	☐ In the past	☐ Never	How much? _____
Substance abuse:	☐ Currently	☐ In the past	☐ Never	What substance? _____

Medications with Dosages (if you need more space, please use back of form)

If you are not currently taking any medications, please check the box at right. ☐ No medications to report

_____

_____

Date of Last Tetanus Shot: _____

Reason for Visit

Symptoms: _____

Date of onset: _____

Patient Acknowledgement

The information provided above is correct to the best of my knowledge.
Initial _____

Cares Clinic

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____

I hereby acknowledge that I have received a copy of ICM Cares Clinic's Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

_____
Signature of Patient or Legal Representative

_____
Date

_____
Printed Name of Patient's Representative (*if applicable*)

Relationship to Patient (*if applicable*)
- ☐ Parent or guardian of unemancipated minor
- ☐ Court appointed guardian
- ☐ Executor or administrator of decedent's estate
- ☐ Power of Attorney

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date, _____ but acknowledgment could not be obtained because:

- ☐ Patient/representative refused to sign.
- ☐ Emergency situation prevented us from obtaining acknowledgement at this time. (will attempt again at a later date)
- ☐ Communication barriers prohibited obtaining acknowledgement (Explain)

_____

_____

_____

_____

_____

- ☐ Other (Specify) _____

_____

_____

_____

_____

Authorization for Release of Information

Patient Information

Patient Name
Date of Birth Social Security #
Address
Phone # Email

1. I, hereby authorize ICM Cares Clinic to release protected health information concerning myself to the person(s) or entities named below:

Individual(s) name	Relationship	Phone no.	Address

Organization/Entity name	Address	Phone no.	Fax no.

2. The specific information that can be disclosed includes all medical records, treatments, imaging results, lab test results, progress notes, and any other medical records pertaining to me.
   Other:
3. This authorization is voluntary, and I may refuse to sign this form without affecting my health care or the payment for my health care.
4. I have the right to request a copy of this authorization form after I sign it, as well as inspect any information to be used and/or disclosed under this authorization.
5. I understand that the information used or disclosed may be subject to re-disclosure by the person(s) or entity receiving it and would then no longer be protected by federal privacy regulations.
6. I may revoke this authorization by notifying ICM Cares Clinic in writing. However, I do understand that any action already taken in reliance of this authorization cannot be reversed, and my revocation will not affect those actions.
7. This authorization shall be in effect until revoked by me in writing.

Signature of Patient Date

-or-

Signature of Authorized Representative of Patient Date
Full Name
Relationship to Patient