



Last Name: _____ First Name: _____

Date of Birth: _____ Date of Visit: _____

Age: _____ Sex: MALE FEMALE

Race/ Ethnicity: _____ Preferred Language, if other than English: _____

Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Social Security Number: _____ Marital Status: SINGLE MARRIED
 WIDOWED DIVORCED

Reason for your visit today: _____

Is this an injury resulting from a work or motor vehicle accident? YES NO

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone: _____

Primary Care Physician (PCP) Name: _____

Please note we routinely send correspondence to PCP for continuity of care.

PCP Office Location: _____ PCP Office Phone: _____

Preferred Pharmacy: _____

Location (Cross streets): _____ Pharmacy Phone: _____

In order to process your claim, please complete below if the patient is NOT the POLICY HOLDER on your insurance.

Policy Holder's Name: _____ Relationship: _____

Insured's SSN: _____ Insured's Date of Birth: _____

Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____

Main Phone: _____

Healthcare services that are respectful of, and responsive to, the health beliefs, cultural practices and linguistic needs of a diverse patient group can bring about positive health outcomes. Please let one of our clinical staff know should you have any cultural or religious requests or concerns.

T 813.925.1903 | FastTrackUrgentCare.com | Open 8 a.m. – 8 p.m. 7 days a week
Wesley Chapel | Carrollwood | Westchase | South Tampa | Downtown @ The Heights
Riverview | St. Petersburg | Seminole | Brandon | Sun City Center | Downtown on Water Street

Last Name: _____ First Name: _____

Date of Birth: _____ Date of Visit: _____

- | | | |
|--|------------------------------|-----------------------------|
| I am having severe chest pain and shortness of breath, and I think I may be having a heart attack. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| I am having numbness/weakness in my arms, legs or face, and I think I may be having a stroke. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| I have recently lost consciousness or I am having extreme weakness, and I think I may pass out. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| I am pregnant and I am having vaginal bleeding. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If you answered yes to any of the above questions or if you have a life-threatening medical concern, please notify staff immediately.

Medications:

None

Please list all medications that the patient is currently taking: _____

Please note: Our physicians will not write for, dispense or refill Schedule II or Schedule III drugs- including narcotics (such as hydrocodone, oxycodone, Percocet, Vicodin), benzodiazepines (such as Xanax, lorazepam), or amphetamines (such as Adderall, phentermine), written by other providers.

Past and Current Medical Conditions:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> None | <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Acid Reflux / GERD | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Peripheral Artery Disease |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Depression | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Irritable Bowel (IBS) | <input type="checkbox"/> Seizures/Epilepsy |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Enlarged Prostate | <input type="checkbox"/> Joint Injuries | <input type="checkbox"/> STD |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Erectile Dysfunction | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Skin Cancer |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Gastrointestinal Ulcers | <input type="checkbox"/> Lung Cancer | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Broken or Fractured Bone(s) | <input type="checkbox"/> Gout | <input type="checkbox"/> Lupus | <input type="checkbox"/> Other / Not Listed |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Migraine | _____ |
| <input type="checkbox"/> Clotting Disorder | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Obesity | _____ |
| <input type="checkbox"/> Colon/Rectal Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Osteoporosis | _____ |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Overactive Bladder | _____ |

Drug Allergies:

- | | | | |
|--|---------------------------------------|---|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Depakote | <input type="checkbox"/> Morphine | <input type="checkbox"/> Other / Not Listed |
| <input type="checkbox"/> Amoxicillin | <input type="checkbox"/> Dilantin | <input type="checkbox"/> Other Antibiotics | _____ |
| <input type="checkbox"/> Anti-Seizure Medicine | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Other Pain Killers | _____ |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Insulin | <input type="checkbox"/> Penicillin | _____ |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Iodine | <input type="checkbox"/> Sulfa | _____ |
| <input type="checkbox"/> Contrast Dye | <input type="checkbox"/> Latex | | |

Surgeries or Procedures:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Colon/Bowel Surgery | <input type="checkbox"/> Kidney Surgery | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Cosmetic Surgery | <input type="checkbox"/> Mastectomy | <input type="checkbox"/> Tubal Ligation |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Gallbladder Surgery | <input type="checkbox"/> Neurosurgery | <input type="checkbox"/> Vasectomy |
| <input type="checkbox"/> Back Surgery | <input type="checkbox"/> Gastric Bypass | <input type="checkbox"/> Orthopedic Surgery | <input type="checkbox"/> Other / Not Listed |
| <input type="checkbox"/> Breast Biopsy | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Pacemaker Implantation | _____ |
| <input type="checkbox"/> Cardiac Stent / Catheterization | <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> Prostate Surgery | _____ |
| <input type="checkbox"/> Cataract Surgery | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Sinus Surgery | _____ |
| <input type="checkbox"/> Cesarean Section | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Thyroid Surgery | _____ |



Hospitalizations:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Other / Not Listed |
| <input type="checkbox"/> Alcoholism or Substance Abuse | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | _____ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Pneumonia | _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures / Epilepsy | _____ |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Injury | <input type="checkbox"/> Thyroid Disease | |

Family Medical History:

	Father	Mother	Grandfather	Grandmother	Siblings	Children
Acid Reflux / GERD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disorder / Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression / Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease / Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures or Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other / Not Listed						

Social History:

- | | | |
|---------------------------|------------------------------|-----------------------------|
| Are you a current smoker? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you drink alcohol? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you drink caffeine? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Review of Systems: Please mark all recent symptoms associated with today's visit.

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Runny Nose | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Loss of Consciousness |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Nausea | <input type="checkbox"/> Weakness or Paralysis |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Tingling or Numbness |
| <input type="checkbox"/> Weight Loss (unintentional) | <input type="checkbox"/> Loss of Voice | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Weight Gain (unintentional) | <input type="checkbox"/> Postnasal Drip | <input type="checkbox"/> Constipation | <input type="checkbox"/> Easy Bruising |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Throat Swelling | <input type="checkbox"/> Dark Tarry Stools | <input type="checkbox"/> Easy Bleeding |
| <input type="checkbox"/> Loss of Vision | <input type="checkbox"/> Dental Pain | <input type="checkbox"/> Blood in Stools | <input type="checkbox"/> Leg Cramps |
| <input type="checkbox"/> Blurring of Vision | <input type="checkbox"/> Neck Stiffness | <input type="checkbox"/> Pain with Urination | <input type="checkbox"/> Heat or Cold Intolerances |
| <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Swollen Neck Glands | <input type="checkbox"/> Frequent Urinations | <input type="checkbox"/> Increased Thirst |
| <input type="checkbox"/> Eye Irritation or redness | <input type="checkbox"/> Chest Pain (Cardiac) | <input type="checkbox"/> Strong Urge to Urinate | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Itchy Eyes | <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Difficulty Urinating | <input type="checkbox"/> Itchy Skin |
| <input type="checkbox"/> Drainage from Eyes | <input type="checkbox"/> Leg Swelling | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Dry Skin |
| <input type="checkbox"/> Earache | <input type="checkbox"/> Cough | <input type="checkbox"/> Urine Output Changes | <input type="checkbox"/> Lumps or Swelling |
| <input type="checkbox"/> Decreased Hearing | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Changes in Hair or Nails |
| <input type="checkbox"/> Ringing of Ears | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Joint Swelling | <input type="checkbox"/> Depressed Mood |
| <input type="checkbox"/> Ear Discharge | <input type="checkbox"/> Coughing up Blood | <input type="checkbox"/> Muscle Aches | <input type="checkbox"/> Sleep Disturbances |
| <input type="checkbox"/> Sinus Pain or Pressure | <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Other / Not Listed |
| <input type="checkbox"/> Nasal Congestion | <input type="checkbox"/> Painful Swallowing | <input type="checkbox"/> Back Pain | _____ |



Last Name: _____ First Name: _____
Date of Birth: _____ Date of Visit: _____
Preferred Email: _____ (To receive future notifications, please opt in on your initial email)

Patient Responsibilities

Thank you for choosing TGH Urgent Care powered by Fast Track. We are committed to providing you with quality and affordable healthcare. To address some common questions, we have developed this Patient Responsibility Form. Feel free to ask any questions.

- 1. Self-Pay - Uninsured or out of network insurance patients must pay for service at the time of the visit.
2. Insurance - We participate in many insurance plans, see our website for a list.
a. All patients must complete our Patient Demographic Form for each visit to ensure current and accurate information on file.
b. We make every effort to verify and collect accurate patient responsibility with your insurance carrier.

- 3. Non-covered Services - Please be aware that some and perhaps all of the services you receive may not be covered or not considered reasonable or necessary by your insurer. The following services typically are not covered:

Table with 2 columns listing services not covered: School/Sports Physicals, Employment and DOT Physicals, Travel and Wellness Physicals, PPD (Tuberculin Skin Test), Routine Vaccinations, Form Completion (Medical Leave/Disability), Prescribed Medications, Medical Equipment (Crutches, Braces, etc.)

You are responsible to pay for these services at the time of the visit. It is important to note, these services may be covered by your insurance at another office, such as your primary care physician's office. Knowing your insurance benefits is your responsibility.

For your convenience, we carry commonly prescribed medications onsite. If you are prescribed a medication we stock, you will have the opportunity to purchase it at check-out. We do not bill insurances for these medications. Payment is due at check-out and any charges unpaid at check-out will be billed.

- 4. Claims Submission - Your insurance is a contract between you and your insurance company which we are not party to the contract.
a. After 10 days, should medical claim information for auto accidents, workers compensation or employer requested services not be obtained, patient will be responsible for payments.

- 5. Accounts on File - We require all commercially insured patients to establish an Account on File where our processing system will store a payment method (debt/credit card or bank account information) using an encryption and tokenization process to electronically debit your account according to the Card on File Agreement.
6. Billing Questions - For questions about your bill, please call our billing office, Monday through Friday between 8 AM - 5 PM at 813-616-6670.

- 7. Non-payment - If your account is +90 days past due, you will receive a letter stating that you have 20 days to pay your account is full.
8. Privacy Practices - You have the right to receive a copy of our office Notice of Privacy Practices to signing this consent.

- 9. Pathogen Exposure Policy - In the event any healthcare provider is exposed to my blood and/or body fluids, I shall be deemed to have consented to laboratory testing for HIV, Hepatitis B, and Hepatitis C with release of results to the person exposed.

- 10. Fraud - Any person who, knowingly and with intent to injury, defraud, or deceive and employer or employee, insurance company, or self-insured program, files a statement of claim containing and false or misleading information commits insurance fraud, punishable as provided in s. 817.234 under Florida statutes.

Thank you for reviewing our policy.

I hereby acknowledge I have read and understand this policy and agree to abide by its guidelines.

Patient Signature (or Authorized Patient Representative)

Date