10605 Scripps Poway Parkway • #C
San Diego, CA 92131
Tel: (858) 622-0554 • Fax: (858) 622-1417
Monday - Friday - 8:00am - 8:00pm
Wknds & Holidays - 8:00am - 6:00pm
OPEN EVERY DAY OF THE YEAR!!!

PATIENT REGISTRATION FORM

* REQUIRED INFORMATION	PATIENT ID #
*Patients Full Name:	* Email Address:
*Social Security No:	*Marital Status: ☐ Single ☐ Married ☐ Divorced
*Date of Birth:	☐ Widowed ☐ Separated ☐ Child
*Sex: ☐ M ☐ F	*Home Phone:
*Street Address:	*Cell Phone:
*Apt./Unit/Suite #:	*Employer:
*City, State, Zip:	*Work Phone:
*Emergency contact **other than yourself:**	*Primary Care Physician:
*Emergency Phone:	*How did you hear about us?
*Relationship to Patient:	**Based on the government regulations we are required to gather the following information:**
***REASON FOR VISIT**:	***PREF. LANGUAGE**: English Other ______________
	***ETHNICITY**: ☐ Hispanic or Latino ☐ Non Hispanic
	***RACE**: ☐ Decline ☐ White ☐ Black or African America
	☐ American Indian or Alaska Native ☐ Asian
If patient is under 18 yrs. of age, parent signature required below:	☐ Native Hawaiian or other Pacific Islander
Parent/Guardian Signature:	

*Required Insurance Information: (THIS SECTION MUST BE COMPLETED BY THE PATIENT)	
Please Complete Primary Policy Holders Information:	
Insurance Holders Name:	**Relationship to Patient: ☐ Self ☐ Parent ☐ Spouse**
Insurance Holders DOB:	**Insurance Holders SSN:**
Primary Insurance Company:	**Copay:**
Member ID:	**Group Number:**
Secondary Insurance:	**Copay:**
Member ID:	**Group Number:**

Office policy on Payment: it is our policy to require payment of all office charges at the time they are rendered, unless prior arrangements have been specifically made. In the event any balance due hereunder is not paid as agreed, the under signed jointly and severally agree to authorize a credit card transaction on their account and pay all costs charged by the collection company and reasonable attorneys fees. Please note, we do not bill third parties for your visit, i.e. Personal Injury Protection Insurance, Lawyers or other parties

I have reviewed the MD Today Urgent Care, Len Jurkowski MD's Family Practice & Jurkowski Medical Corporation's Privacy Standards Notice of Health Information Practices. I agree to all terms and conditions on the back of this form and accept financial responsibility in full for this account, in the event of nonpayment from my insurance carrier.

***Signed:** ____ ***Date:** ____________________

MD Today Urgent Care & Jurkowski Medical Corporation Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. ***PLEASE REVIEW IT CAREFULLY.***

OUR PLEDGE REGARDING MEDICAL INFORMATION: The privacy of your medical information is important to us. We understand that your medical information is personal, and we are committed to protecting it. We create a record of the care and services you receive at our organization, and we need this record to provide you with quality care and to comply with certain legal requirements. This notice will describe the ways we may use and share this information.

INSURANCE POLICY: Insurance provides for your reimbursement on allowed medical charges. As a courtesy to you, we will provide an itemized statement that you may send to your insurance company for payment. We will be happy to submit to most insurance carriers, if you have provided us with accurate policy information. You are responsible for all deductibles not covered by insurance. Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations, this is your responsibility. We do not participate with any Medical Assistance policies. We do not bill insurance carriers for Travel Immunizations.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS: I authorize the Doctor to release any medical information and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, and at times when the Doctor deems it necessary in order to ensure the best medical care on my behalf. I further understand that any person(s) that receive these medical records will not release any of the information obtained by this authorization without a further authorization signed by me for release of the information.

USE AND DISCLOSURE: **Treatment**. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by our staff members.
Reminders/Notifications. Our staff will use your health information to send you follow-up care, referral or appointment reminders. We may also send you information describing changes occurring at MD TODAY URGENT CARE & JURKOWSKI MEDICAL CORPORATION such as, address changes, new locations or changes in business hours.
Treatment Information. Your health information may be used to send you information that you may find interesting on the treatment and management of you medical condition. We may also send you information describing other health-related products and services that may be of interest to you.
Payment. We may use and disclose your medical information for payment purposes. We may need to give your health insurance plan information so that your health plan will pay us or repay you for services.
Healthcare Operations. Your health information may be used as necessary to support the day-to-day activities and management of MD TODAY URGENT CARE & JURKOWSKI MEDICAL CORPORATION. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs and getting accreditation, certificates, licenses and credentials we need to serve you.
Law Enforcement. Your health information may be disclosed to law enforcement agencies, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.
Public Health Reporting. Your health information may be disclosed to public health agencies as required by law.
Workers Compensation. We may disclose health information to workers compensation or other similar programs.
Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.
INDIVIDUAL RIGHTS: You have certain rights under the federal privacy standards. These include: • the right to request restrictions on the use and disclosure of your protected health information, • the right to receive confidential communication regarding your medical condition and treatment, • the right to inspect and copy your protected health information, • the right to an accounting of how and to whom your protected health information has been disclosed, • the right to receive a printed copy of this notice

JURKOWSKI MEDICAL CORP & MD TODAY URGENT CARE DUTIES: We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

RIGHT TO REVISE PRIVACY POLICIES: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

REQUESTS TO INSPECT PROTECTED HEALTH INFORMATION: You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the receptionist or Privacy Official. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

COMMENTS & COMPLAINTS: If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to this office, attention: Privacy Official.
If you believe that your privacy rights have been violated, you should bring the matter to our attention by sending a letter describing the cause of your concern to the address listed above. You will not be penalized or otherwise retaliated against for filing a complaint.

FOR ADDITIONAL INFORMATION: Please inquire at the reception desk for a copy of the MD TODAY URGENT CARE & JURKOWSKI MEDICAL CORPORATION Privacy Standards.
EFFECTIVE DATE: This notice is on or after January 1, 2012.

MDtoday URGENT CARE

MEDICAL HISTORY

NAME: ____________________________________ DATE OF BIRTH:(M/D/YR)____/_____/______

ALLERGIC TO LATEX: Yes No HEIGHT: ___________ WEIGHT:_______LBs

ALLERGIC TO MEDICATIONS: Yes No ____

CURRENT MEDICATIONS: ____

____

____

SYSTEM REVIEW: Please check AND describe any active problem or symptom.

General Symptoms (i.e. fever, weight gain/loss, fatigue) ______________________________

- ☐ Eyes/Ears/Nose/Throat__________________________
- ☐ Allergies/Rashes______________________________
- ☐ Endocrine (Diabetes/Thyroid)____________________
- ☐ Skin and/or Breasts___________________________
- ☐ Lungs_____________________________________
- ☐ Psychiatric_________________________________
- ☐ Heart_____________________________________
- ☐ Muscles/Bones/Joints__________________________
- ☐ Bleeding/Lymph Nodes_________________________
- ☐ OB/Genital/Urinary___________________________
- ☐ Nerves____________________________________
- ☐ Abdomen___________________________________

SOCIAL HISTORY:

Occupation: _______________ Marital Status _____________ Children: Yes No Live Alone: Yes No

Tobacco Use: Never In the Past Presently How Much? __________ How Long? ____________

Alcohol Use: Daily Occasional None Other substance use or abuse? Yes No _______________

PAST MEDICAL HISTORY: Please check any illnesses/conditions which YOU have had.

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Vein Trouble
- ☐ Kidney Disease
- ☐ Thyroid Problems
- ☐ Drug Abuse/Alcoholism
- ☐ Joint Replacement
- ☐ DVT
- ☐ Pulmonary Embolus
- ☐ Tuberculosis
- ☐ Nervous Disorder
- ☐ Sinus
- ☐ Tonsillitis
- ☐ Bleeding Tendencies
- ☐ Lung Disease
- ☐ Asthma
- ☐ Heart Trouble
- ☐ Seasonal Allergies
- ☐ Arthritis
- ☐ Gastrointestinal
- ☐ Cancer: If Yes, What Type ______________
- ☐ Stroke
- ☐ Diabetes
- ☐ Pneumonia
- ☐ HIV
- ☐ Hepatitis
- ☐ Osteoporosis

Other: ____

Any Serious Injuries / Illnesses? YES NO If yes, please describe below.

____

SURGICAL HISTORY and or SURGICAL COMPLICATIONS? Please list

____

FAMILY MEDICAL HISTORY: Please check any illnesses/conditions immediate FAMILY has had.

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Vein Trouble
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Drug Abuse / Alcoholism
- ☐ Joint Replacement
- ☐ Cancer Type
- ☐ DVT
- ☐ Pulmonary Embolus
- ☐ Tuberculosis
- ☐ Nervous Disorder
- ☐ Seizures
- ☐ Thyroid Problems
- ☐ Hepatitis
- ☐ Bleeding Tendencies
- ☐ Lung Disease
- ☐ Asthma
- ☐ Heart Trouble
- ☐ Seasonal Allergies
- ☐ Ear Problems
- ☐ Arthritis
- ☐ Gastrointestinal
- ☐ Stroke
- ☐ Diabetes
- ☐ Pneumonia
- ☐ HIV
- ☐ Sinus
- ☐ Tonsillitis
- ☐ Osteoporosis

Other: ____

WORK RELATED INJURY: Please fill out this section ONLY IF this injury occured at work.

Date of Injury___/____/____ Describe how the injury happened ______________________________

Have you had the same injury in the past? Yes No When did you report the injury to your employer? ___/___/____

Please Circle one: Left Right Handed Were you wearing portective devices/clothing?___________________

Any recent changes in work that contributed to this injury? Yes No If yes, please describe______________

Please list any sport/recreational activities you've participated in last year__________________________

List any activities you feel you can no longer perform as a result of your injury_______________________