ANDERSON WALK-IN
MEDICAL CLINIC
WE CARE FOR YOU

PATIENT REGISTRATION FORM

Last Name: _____ First: _____ M.I.: ____

DOB: ____ / ____ /_____ Gender: ____ Male ____ Female SS# _____ - ____ - _____

Marital Status: _____ Single _____ Married _____ Widowed _____ Divorced

Ethnicity: _____ Hispanic: ____ No ____Yes

Mailing Address: _____ Apt.: _____

City: _____ State: _____ Zip Code: _____

E-mail: _____

Home Phone: _____ Cell Phone: _____

Mother's Maiden Name: _____

Preferred Pharmacy / Location: _____

EMERGENCY CONTACT:

Last Name: _____ First: _____ M.I.: ____

Relationship to Patient: _____

Home Phone: _____ Cell Phone: _____

NEW PATIENT MEDICAL HISTORY

Patient Name: _____ DOB: ____ / ____ /_____

Your answers on this form will help your clinician better understand your medical concerns and condition. Best estimates are fine if you cannot remember specific details.

REASON FOR VISIT: _____

Name of primary care provider: _____

ALLERGIES or REACTIONS TO MEDICATIONS / FOODS / OTHER AGENTS:

Allergic to:	Reaction or Side Effect:

☐ No known drug allergies.

MEDICATIONS: Prescriptions and non-prescription medicines, vitamins, and birth control pills.

Medication:	Dose:	Times per Day:

WHEN WAS YOUR MOST RECENT:

Tetanus Immunization: _____ Shingles Immunization: _____ Pneumonia Vaccination: _____

Mammogram: _____ Colonoscopy: _____ PAP: _____

WOMEN'S GYNECOLOGIC HISTORY:

First day of most recent period: _____ Possibility of Pregnancy? _____ Yes _____ No

PERSONAL MEDICAL HISTORY:

☐ Alcoholism
☐ Abnormal PAP smear
☐ Blood disorder
☐ Cancer (type: _____)
☐ Congenital heart disease
☐ Depression / Anxiety
☐ Diabetes (Type 1 – requires insulin)
☐ Diabetes (Type 2)
☐ High cholesterol
☐ Hypertension (high blood pressure)
☐ Myocardial infarction (heart attack)
☐ Stroke
☐ Thyroid problem
☐ Other: _____

Patient Name: _____ DOB: ____ / ____ /_____

SURGICAL HISTORY:

Operation:	Date:

FAMILY HISTORY: Mark any of your family members who have / had any of the following illnesses.

Disease:	Mother	Father	Sister	Brother	Son	Daughter	Grandmother	Grandfather
Alzheimer's								
Cancer								
Diabetes								
Heart Attack								
Heart Disease								
Other: _____								
Other: _____								

SUBSTANCE USE HISTORY:

Tobacco / Nicotine Use	Alcohol Use	Drug Use
Are you a cigarette smoker? ☐ Yes ☐ No ☐ Never ☐ Quit (date: _____) Pack(s) per day: _____ Number of years: _____ Other Tobacco / Nicotine use: ☐ Cigar ☐ Chew ☐ Pipe ☐ Vaporizer (Vape)	Do you drink alcohol? ☐ Yes ☐ No Drinks per week: _____	Do you use recreational drugs? ☐ Yes ☐ No If yes, what are you using? _____ _____ _____ _____ _____

ADMISSION POLICY

Anderson Walk-In Medical Clinic always accepts new patients. We are currently enrolled in Medicare, Partnership, Medi-Cal, and some Blue Cross, Blue Shield, Aetna and Cigna networks. We accept most insurance plans, BUT IT IS THE PATIENT'S RESPONSIBILITY TO DETERMINE IF WE ARE IN-NETWORK FOR THEIR INSURANCE PLAN. We are also listed as Preferred Providers on numerous industrial company lists such as State Compensation Insurance Fund, Frank Gates and Preferred Employers.

Anderson Walk-In Medical Clinic adheres to a very strict pain policy.

Anderson Walk-In Medical Clinic does not have any mental health medical professionals on staff. All mental health related issues are referred elsewhere for management of care.

Anderson Walk-In Medical Clinic does provide care for all family practice / general practice medical needs.

Anderson Walk-In Medical Clinic is fully equipped to handle all minor injuries including: lacerations, foreign body removal, incision / drainage, and sprains / strains.

Anderson Walk-In Medical Clinic provides women's yearly exams and sports physicals.

Anderson Walk-In Medical Clinic can provide pre-employment drug screening.

Anderson Walk-In Medical Clinic can provide service physicals (i.e. DMV, Forest Service).

You must arrive 15 minutes prior to your appointment. If you're a new patient, visiting the clinic for the first time, please arrive 20 minutes prior to your scheduled appointment. Late arrivals may be rescheduled.

We welcome you to Anderson Walk-In Medical Clinic. We hope that our level of care exceeds your expectations. If you have any questions or concerns, please feel free to contact the clinic administrator at (530) 365-4412.

_____	_____	___ / ___ / _____
Print Patient Name	Signature of Patient or Guardian	Date

If your visit to the clinic is not covered by your insurance, you will be required to pay 100% of the office visit. It is your responsibility to determine if your insurance plan covers office visits.

_____ Please initial. This indicates that you have read and agree with the statement above.

INSURANCE BILLING POLICY

Anderson Walk-In Medical Clinic offers a courtesy billing service to all patients that have private medical insurance. It is the policy of the clinic to submit medical bills to your private insurance provider the following day of your visit. Therefore, all patients must have their insurance card(s) present at the time of their first visit, and any time after that if the coverage has changed. If you do not have your medical insurance card present at the time of your visit, you will be asked to either leave a post-dated check or pay for your services with cash, check, or credit card. We are happy to courtesy-bill your insurance company for you, once you have provided our office with all required insurance information. You will be fully responsible to pay any and all deductible amounts at the time of your service, as well as any co-pay amount that your insurance provider has required from you for your plan.

Anderson Walk-In Medical Clinic does not provide any third-party billing. For example: car accident claims, personal injury claims, or any pre-existing industrial injury claims. If the medical service you are receiving today fits into any of these areas, please see the receptionist immediately.

Anderson Walk-In Medical Clinic does not currently work on a sliding fee scale, and we do not do any personal billing for someone without medical insurance. We expect payment at the time of the visit (if we are not billing an insurance provider) for services rendered. We will hold a post-dated check for up to three weeks, or we can set up an automatic electronic debit from your checking or savings account for the unpaid balance of the bill.

I acknowledge liability for all medical expenses incurred, whether the expenses are covered by my insurance provider or not. If any expenses remain unpaid for any reason, including but not limited to insurance deductible, policy limits, or plan exclusions, I agree to pay any remaining amount to Anderson Walk-In Medical Clinic. I hereby assign Anderson Walk-In Medical Clinic any and all money in which I am entitled to for medical or surgical expenses relative to the services reported herein.

Name of insurance provider: _____

Has your deductible been met for this year? _____ Yes _____ No

What is your co-payment amount? _____

_____	_____	___ / ___ / _____
Print Patient Name	Signature of Patient or Guardian	Date