FASTER CARE

PATIENT REGISTRATION

PATIENT NUMBER

Patient Information

LAST NAME _____

FIRST NAME _____ MI ___

DATE OF BIRTH _____ / _____ / _____ SEX _____

RACE _____

MARITAL STATUS □ MARRIED □ SINGLE □ DIVORCED □ WIDOWED

SSN#: ___-___-___ - ___-___ - ___-___-___-___

_____

EMPLOYER _____

HOME ADDRESS _____

_____

CITY _____ STATE _____ ZIP _____

EMAIL _____

HOME PHONE (__ - __ - __) ___-___-___ - ___-___-___

CELL PHONE (__ - __ - __) ___-___-___ - ___-___-___

WORK (__ - __ - __) ___-___-___ - ___-___-___-___

PRIMARY PHYSICIAN _____

HOW DID YOU HEAR ABOUT US: _____

EMERGENCY CONTACT

Name:_____ Phone: _____

FINANCIALLY RESPONSIBLE PARTY
(PARTY MUST BE PRESENT TO PROVIDE SIGNATURE IN ORDER TO ACCEPT FINANCIAL RESPONSIBILITY)

RESPONSIBLE PARTY'S NAME:_____ DATE OF BIRTH:_____

ADDRESS (IF DIFFERENT):_____CITY:_____ STATE:_____ ZIP:_____

SOCIAL SECURITY #_____PHONE:_____ SIGNATURE:_____ DATE: _____

INSURANCE POLICY HOLDER (THE INDIVIDUAL WHOSE NAME THE INSURANCE IS UNDER)

RELATIONSHIP _____

LAST NAME_____

FIRST NAME_____ MI _____

DATE OF BIRTH _____ / _____ / _____

SSN # ___-___-___ - ___-___ - ___-___-___-___

PH : (__ - __ - __) ___-___-___ - ___-___-___

ADDRESS _____

CITY _____STATE _____ ZIP _____

EMPLOYER _____

ADDRESS _____

PH: (__ - __ - __) ___-___-___ - ___-___-___

Please read and sign the four statements below. Providing your signature acknowledges that you have read, understood, and are agreeable.

If you have any questions regarding any of these statements please ask the receptionist before providing your signature. Thank you.

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I also authorize Faster Care or my insurance company to release any information required to process my claims. I consent to treatment by the physicians of Faster Care and to appropriate tests for the presence of infection, such as, but not limited to Hepatitis B Virus, Hepatitis C Virus, or HIV if deemed necessary and authorize the withdrawal of blood or other body fluids for this purpose.	**X** **Signature** (patient or parent if patient is a minor) **Date**
RECEIPT OF NOTICE OF PRIVACY PRACTICES: I verify that I have received a copy of Faster Care's notice of privacy practices.	**X** **Signature** (patient or parent if patient is a minor) **Date**
I am aware that ALL radiographic studies including but not limited to x-rays, cat scans and ultra sounds will be read by a radiologist who will require a separate payment. All laboratory procedures not executed at FastER Care will also require a separate payment. The patient will be responsible for these charges, not Faster Care.	**X** **Signature** (patient or parent if patient is a minor) **Date**
Payment for the patient portion will be collected at the time of service; including co-pays, coinsurance, and any portions of your unpaid deductible. Collection accounts will receive a $50.00 charge on all unpaid balances. Bounced checks will receive a $30.00 charge.	**X** **Signature** (patient or parent if patient is a minor) **Date**

PATIENT NAME:	DATE OF BIRTH:
ADDRESS:	CITY/STATE/ZIP:
TELEPHONE:	SOCIAL SECURITY NUMBER:

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION AS INDICATED BELOW:

FROM:	TO:
Practice Name: FASTER CARE INC.	Name:
Address: 3440 DECLARATION BLVD. SUMTER SC 29154	Address:
Phone/Fax: 803-905-3278/ 803-905-3282	Phone/Fax:

I AUTHORIZE THE FOLLOWING INFORMATION TO BE RELEASED: (PLEASE CHECK)

o OUTPATIENT NOTES	o RADIOLOGY REPORT(S)
o PATHOLOGY REPORTS	o COMPUTER DISC OF RADIOLOGY IMAGES
o IMMUNIZATION RECORDS	o ALL MEDICAL RECORDS
o OTHER: _____	

I AUTHORIZE INFORMATION REGARDING THE FOLLOWING INFORMATION (please check)

The diagnosis/treatment of STD's including HIV tests	o YES o NO
The diagnosis/treatment of drug/alcohol abuse	o YES o NO
The treatment/consultation for mental health or psychiatric disorders	o YES o NO

This authorization is set to expire in ninety (90) days. Please change expiration to date: _____.

I understand that this Authorization may be revoked at any time via written request sent to Faster Care at address above. Release of required information to enrolled insurance or to employer in relation to worker's compensation is not conditioned upon this agreement.

Once these records are released, this information cannot be protected by Faster Care Ins and may potentially re-disclosed by the party who received these records. Faster Care Ins, its employees and officers, and attending physicians are released from legal responsibility or liability for release of the above information to the extent indicated and authorized.I have read and understand this information. I have received a copy of this form and I am the patient/legal guardian or am authorized to act on behalf of the patient to sign this document verifying authorization for the use of disclosure of the protected health information under the above stated terms.

Signature of Patient:	Date:
Signature of legal representative and relationship to the patient:	Date:
Signature of witness:	Date:

1. Last Name_____First Name_____
2. Address:_____
3. City, State, Zip:_____
4. Phone:_____DOB:_____Age:_____
5. Weight:_____ Height:_____
6. Who is your regular doctor?_____
7. What pharmacy do you want to use today?_____
This will be the pharmacy you use today. NO EXCEPTIONS
8. **Will you need a work or school note?** Circle: **WORK SCHOOL NONE**

9. What is your chief complaint today and when did it start:
_____
10. List symptoms:_____
_____

11.Do you have any medical conditions? **Circle: YES or NO** If yes, please list:
_____
_____
_____

12. Are you allergic to any medications? **Circle: YES or NO** If yes please list:_____
_____

13. Do you take any medications? **Circle: YES or NO** If yes, please list names of each: _____
_____
_____

14. Have you ever had any surgeries: **Circle: YES or NO** If yes, please list:
_____
_____

15. Have you ever been hospitalized? **Circle: YES or NO** If yes, please list reason:
_____
_____
_____

16. Date of Last Tetanus:_____
If applicable, are your child's immunizations up to date? **YES or NO**

Office Use: Time:
Ins:
Pre-auth:
Y or N

BP: BP:
P: P:
R: R:
T: T:
O2: O2:
OFFICE USE, LEAVE BLANK.

17. **Women:** Date of last period?_____ Are you pregnant or nursing? **YES or NO**_____

18. **Please list hereditary medical conditions of people listed regardless if alive or deceased:**
Father: [_] alive [_] deceased_____
Mother: [_] alive [_] deceased_____
Siblings: [_]alive [_] deceased_____
Children: [_] alive [_] deceased_____

19. Do you have someone to make medical decisions on your behalf should you become unable to make the decisions
for yourself? **YES or NO**
Name:_____Phone:_____

Address:_____

20. Do you □ smoke □ use smokeless tobacco □ vape □ none
If yes, how much/how often per day?_____

-Use illegal drugs/substances? **YES or NO** If yes, what and how much? _____

-Do you drink alcohol? **YES or NO** If yes, please answer the following:
***How often did you drink alcohol this past year?
[_]Never [_]Monthly or less [_] 2-4 a month [_]2-3 a week

***How many drinks did you have on a typical day when you were drinking?
[_]1-2 [_]3-4 [_]5-6 [_]7-8 [_]10 or more

***How often did you have 6 or more drinks on one occasion in the past year?
[_]Never [_]less than monthly [_]Monthly [_]Weekly [_]Daily or almost daily