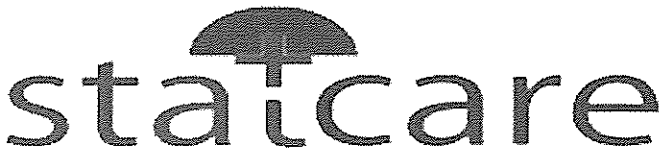

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DOWNTIME FORM
ADMISSION-REGISTRATION-URGENT CARE

Personal Info:

Account Number: _____ Prefix: _____ PCP: _____

Last Name: _____ Suffix: _____ Referring provider: _____

First Name: _____ MI: _____ Rendering Provider: _____

Previous Name: _____ Date of Birth (mm/dd/yyyy): _____

Address Line 1: _____ Sex: _____ Transgender: _____

Address Line 2: _____ Social Security: _____

City/State: _____ Country: _____ Marital Status: _____

Home phone: _____ Cell: _____ Employer Name: _____

Work Phone: _____ Ext: _____ EMP Status: _____ (none Selected)

(Statements will be addressed to responsible party) Student Status: ____ (none selected)

Responsible Party Name: _____ Emergency Contact: _____

Relation: _____ Acct Balance: _____ Patient Balance: _____

Last Appt: _____ Next Appt: _____

Insurance IE

Fee for Schedule _____ Self pay: __ Add:_ Update: _ Remove: ___

Insurance Name:_____ Sate: ____ Subscriber: _____ Rel: ___

Co- pay: $_____ Group No: _____

Release of information ___ Yes __ No Rx History Consent: _____Yes ___ No

Signature Date: _____ Advance Directive: _____

General Notes:

_____

_____

Pateient Email Address: _____

Additional Info:

____ Don't Sent Statements _____ Inactive _____ Don't add finance change

Street Address (if different from mailing)

Address Line 1:_____

Address Line 2: _____

City: _____ State: _____ Zip: _____

Email: _____

Race: _____ Ethnicity: _____ VFC: _____

_____ Consent to report immunizations.

Employer Address:

Address Line 1: _____ Default Facility: _____

Address Line 2: _____ MRN (External System): _____

City: _____ Default Lab Company: _____

State: _____ Zip: _____Default DI Company: _____

Language: _____ Translator: _____

Pharmacies:

_____

_____

Facility Location:_____

Date: _____ Provider: _____

Claim Providers Resource: _____

Start Time: _____ End Time: _____ New Patient: _____

Visit Type: _____

Visit Status: _____ Reson: _____

Diagnosis _____ Transition of care: _____

Billing notes: _____

General Notes: _____

Co- pay/ Claim changes for this visit only:

_____ change co-pay for this visit _____ non- billable visit

Charge Details:

statcare
Urgent & Walk-In Medical Care

MA Progress Note

Patient Name :_____

Date of Birth:_____

Date of Service :_____

Height			
Weight			
Temp			
Pulse oximetry			
Test			

	Past Medical History Surgeries and Current Symptoms
PMH	
Surgery	
Current Symptoms	

Staff Initials :_____

Title:MA