Wakulla Urgent Care & Diagnostic Center

41 Feli Way, Crawfordville, FL 32327-2368
David A. Keen, M.D & Valerie M. Russell, ARNP

REGISTRATION FORM

(Please Print)

Today's Date:	Your Regular Doctor:

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	Marital Status: ☐ Single ☐ Mar ☐ Div ☐ Sep ☐ Wid

Is this your legal name ☐ Yes ☐ No	If not, what is legal name?	(Former name):	Birth Date:	Age:	Sex: ☐ M ☐ F

Street address	Social Security #:	Home phone #: ( )

P.O. Box	City:	State:	Zip Code:

Occupation:	Employer:	Employer phone #: ( )

E-mail Address:		
Referred by:	Language Spoken:	Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Race: ☐ Caucasian ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Hawaiian or Other Pacific Islander ☐ Other

INSURANCE INFORMATION

(Please give your insurance cards and picture ID to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone #: ( )

Is this person responsible for the bill a patient here? ☐ Yes ☐ No

Occupation:	Employer:	Employer address:	Employer phone #: ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Name of Primary Insurance:					
Subscriber's name:	Subscriber's S.S. No:	Birth Date:	Policy #:	Group #:	Co-payment: $

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Name of Secondary Insurance (if applicable):	Subscriber's name:	Policy #:	Group #:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no: ( )	Work phone no: ( )

I certify the above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Wakulla Urgent Care & Diagnostic Center (Dr. David A. Keen and associates). I understand that I am financially responsible for all charges whether they are paid by my insurance or not. I also authorize the practice or the insurance companies to release any information, including health care data, required to process my claims.

_____ _____

Patient/Guardian signature Date

Wakulla Urgent Care & Diagnostic Center
David A. Keen, M.D., M.P.H.

41 Feli Way
Crawfordville, Florida 32327
Phone: 850-926-3140 / Fax: 850-926-3163

Patient Name: _____ DOB: _____

PATIENT MEDICATION LIST
PLEASE LIST **ALL** MEDICATIONS CURRENTLY ON

Medication Name	Dosage	Prescribed by

Any known allergies to medications, if so please list:

Patient Signature: _____ Date: _____

HIPAA Authorization for Release of Information
Wakulla Urgent Care & Diagnostic Center

I hereby authorize use or disclosure of protected health information about myself

(PATIENT NAME)_____(DOB)_____ as described below.

The following people may receive any and all protected health information about myself:
_____ No One

Name	Date of Birth	Phone Number	Relationship

Which of the following communication means are appropriate/acceptable for WUC to communicate with you: (Please check all that may apply)

_____ Home Phone – Leave message to return call – no particulars
_____ Home Phone – Leave message with particulars
_____ Work Phone – Leave message to return call – no particulars
_____ Work Phone – Leave message with particulars
_____ Cell Phone # – _____ Leave message to return call – no particulars
_____ Cell Phone # – _____ Leave message with particulars

In the case of an emergency, or if we are unable to reach you, whom may we contact?
Name: _____ Relationship: _____
Phone #: _____

Parent/Guardian Consent

In the event of my absence or availability, I hereby grant WUC permission to treat my child/ward _____ for any illness or injury he/she may encounter. In addition, in the event that I _____, the parent am not able to bring my child in for care, I grant _____ to bring my child in to be seen and treated by WUC. I understand that all medical records are confidential and will not be released to anyone, except where necessary for further medical care with another physician or medical facility, without my written consent.

I may revoke or withdraw this authorization by notifying **Wakulla Urgent Care & Diagnostic Center** in writing of my desire to revoke it. However, I understand that any action already taken in advance of this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

This authorization will expire on _____.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING.

Signature of patient or authorized representative Date

Signature of Witness or Office Staff Date

Wakulla Urgent Care & Diagnostic Center
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David A. Keen, M.D & Valerie M. Russell, ARNP

Date: _____

PATIENT CONSENT FORM

I hereby grant Wakulla Urgent Care permission to treat myself for any illness or injury I may encounter.

I understand that my medical records are confidential and will not be released to anyone, except where necessary for further medical care with another physician or medical facility, without written consent.

If insurance is to be filed, I grant permission for medical information to be released to the insurance company if required for processing a claim, and hereby assign benefits to Wakulla Urgent Care.

Signature: _____

Witness: _____

Please list two names and phone numbers to call in case of an emergency:

_____

_____

PARENT/GUARDIAN CONSENT FORM

In the event of my absence or availability, I hereby grant Wakulla Urgent Care permission to treat my child/ward _____ for any illness or injury he/she may encounter.

I understand that all medical records are confidential and will not be released to anyone, except where necessary for further medical care with another physician or medical facility, without my written consent.

If insurance is to be filed, I grant permission for medical information to be released to the insurance company if required for processing a claim; and hereby assign benefits to Wakulla Urgent Care.

Signature: _____

Witness: _____

Please list two names and phone numbers to call in case of an emergency:

_____

_____