



1929 University Ave.  
Oxford, MS 38655  
Phone: 662-236-2232  
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www.oxfordurgentclinic.com



Please **NOTIFY STAFF** if you have an emergency such as: **CHEST PAIN, a HEAD INJURY, SHORTNESS OF BREATH, SEVERE ABDOMINAL PAIN, or the WORST HEADACHE OF LIFE** before continuing.



Is this visit the result of an accident?  Yes  No

Did this accident occur at work?  Yes  No

Patient Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M. Name + Suffix \_\_\_\_\_

Sex \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Street Address / P.O. Box \_\_\_\_\_ Apt. / Lot # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Marital Status    S    M    D    WD

Email \_\_\_\_\_ No Email

**GUARANTOR (Person Responsible for bill)**                      same as patient above

Relationship to patient    Spouse    Child    Other \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M. Name + Suffix \_\_\_\_\_

Street Address/P.O.Box \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ SS # \_\_\_\_\_ Phone \_\_\_\_\_

**PRIMARY INSURANCE**                      Name of Ins. \_\_\_\_\_

Patient's Relationship to Policy Holder    Self    Spouse    Child    Other \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M. Name + Suffix \_\_\_\_\_

Policy # \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS # \_\_\_\_\_

**SECONDARY INSURANCE**                      Name of Ins. \_\_\_\_\_

Patient's Relationship to Policy Holder    Self    Spouse    Child    Other \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M. Name + Suffix \_\_\_\_\_

Policy # \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS # \_\_\_\_\_

I consent to treatment for myself or above minor child. I understand that the examination and/or medical treatment I will receive is NOT intended to replace complete medical care by my personal primary care physician. Oxford Urgent Care is contracted with many of the local and national managed care plans. However, there are some plans that we do not currently have contracts with, including Medicaid. If you belong to a plan that we are not contracted with, our insurance/billing office will be glad to file a claim for you with the understanding that full payment is due at the time of service.

It is important for you to understand that the patient is ultimately responsible for knowing their individual benefits/coverage and is responsible for any fees that are not covered by their insurance provider, including durable medical equipment (splints, crutches, ace wraps, etc). If you have any questions concerning the coverage your plan has with Oxford Urgent Care, please contact your insurance provider.

I have reviewed and agree with the above information. I certify that the information I have provided is true and correct to the best of my knowledge.

\_\_\_\_\_  
Patient Signature (if minor, signature of parent/guardian)

\_\_\_\_\_  
Date



### Authorization for Use or Disclosure of Protected Health Information

I authorize my physician and/or administrative and clinical staff of Oxford Urgent Care, to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below, protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices.

**Name, relationship and a personal identification method of persons you wish to allow access – for example:**

<b>Name:</b>	<b>Relationship:</b>	<b>Personal Identification:</b>
<b>John Doe</b>	<b>Father</b>	<b>Date of Birth, Address or last 4 of SS #</b>
_____	_____	_____
_____	_____	_____

Restriction Request: \_\_\_\_\_

This authorization to use and disclose this protected health information is being submitted by my request and shall be in force and effect until revoked in writing by me.

I understand that information used or disclosed pursuant to this authorization may be disclosed by Oxford Urgent Care and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Officer. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information to obtain payment from my health insurance company.

**I hereby acknowledge that I have received a copy of the Notice of Privacy Practices.**

\_\_\_\_\_ Date \_\_\_\_\_  
Signature of Patient or Personal Representative      Print Name of Patient or Personal Representative

Date of Birth of Personal Representative \_\_\_\_\_ Last 4 of SS# \_\_\_\_\_

If not signed by the patient, please indicate relationship and describe authority to act:

Name of Patient: \_\_\_\_\_  
parent or guardian of minor patient  
guardian or conservator of an incompetent patient

TRIAGE FORM



Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**FOR OFFICE USE ONLY**

Insurance: \_\_\_\_\_ Last Visit: \_\_\_\_\_

Date: \_\_\_\_\_ Account Number: \_\_\_\_\_ Room Number: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

How long: \_\_\_\_\_ Level of pain: \_\_\_\_/10 School/Work Excuse Needed? Yes No

Birth Control: Yes No If Yes, What Type: \_\_\_\_\_

Allergies:

\_\_\_\_\_  
\_\_\_\_\_

Medications:

\_\_\_\_\_  
\_\_\_\_\_

Preferred Pharmacy Name: \_\_\_\_\_

Past Medical/Surgical History:

\_\_\_\_\_  
\_\_\_\_\_

Smoke Drink Drug Use

Occupation: \_\_\_\_\_

Married Single Widow/Widower Divorced

Do you have any additional questions for your provider today?

\_\_\_\_\_  
\_\_\_\_\_

**FOR OFFICE USE ONLY**

Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ lbs/kg

Vital Signs: B/P \_\_\_\_\_ Pulse: \_\_\_\_\_ Resp: \_\_\_\_\_ Temp: \_\_\_\_\_ Pulse Ox: \_\_\_\_\_ LMP: \_\_\_\_\_