Pronto Medical Care

515 Airport Rd. Panama City FL, 32405
Phone Number: (850)481-0894 Fax Number: (850)807-5472
Daniel L. Turley, M.D Carlos H. Fernandez PA-C

Please read each line carefully and initial.

- OUR FEE FOR THE PHYSICAL IS $275. THE FEE IS DUE THE DAY OF YOUR APPOINTMENT.
  All CREDIT/DEBIT CARDS MUST HAVE VALID I.D TO MATCH THE NAME ON THE CARD.
  WE ACCEPT VISA, MASTERCARD, DISCOVER or CASH.
  WE DO NOT ACCEPT AMERICAN EXPRESS, PERSONAL CHECKS OR CARE CREDIT.
  THE IMMIGRATION PHYSICAL IS A NON-REFUNDABLE SERVICE.
  INITIAL: _____

- IF YOU ARE PREGNANT, YOU WILL HAVE TO FOLLOW DIFFERENT GUIDELINES AND MUST INFORM US AT THE TIME OF YOUR APPOINTMENT.
  INITIAL: _____

- YOU MUST HAVE VALID FORM OF IDENTIFICATION FOR YOUR PAPERWORK
  (EX. PASSPORT, IDENTIFICATION CARD OR DRIVER'S LICENSE)
  INITIAL: _____

- IT IS THE PATIENT'S RESPONSIBILITY TO KNOW WHEN THEY ARE DUE FOR THEIR 1-693 EXAM. PRONTO MEDICAL CARE IS ONLY TO PERFORM THE MEDICAL EXAM, THE TERMS OF YOUR CASE ARE BETWEEN THE APPLICANT AND IMMIGRATION STATUS.
  INITIAL: _____

- IF FOR ANY REASON YOUR PHYSICAL MUST BE RE-DONE, THE PATIENT WILL BE RESPONSIBLE FOR THE COST OF THE PHYSICAL, ADDITIONAL FEES, VACCINES AND LAB TESTING.
  INITIAL: _____

- PLEASE BE AWARE THAT IMMIGRATION AND THE CDC ARE VERIFY SPECIFIC ON THE REQUIREMENTS. BE SURE TO FOLLOW ALL STEPS AND INSTRUCTIONS TO AVOID ERRORS. THIS PROCESS CAN BECOME LENGTHY, WE CAN NOT GUARANTEE YOUR PAPERWORK WITHIN ANY CERTAIN TIME FRAME.
  INITIAL: _____

- BASED ON LAB TESTING RESULTS IF FOR ANY REASON YOU REQUIRE TREATMENT OR REFERRALS FOR FURTHER EVALUATION DUE TO THE OUTCOME OF YOUR LAB RESULTS. REQUIRED BY USCIS **YOU MUST COMPLY** AND THIS WILL PROLONG THE COMPLETION OF YOUR I-693 FORMS.
  INITIAL: _____

- YOUR I-693 FORMS ARE IN **ENGLISH**. IF YOU ARE NOT FLUENT WITH **READING OR WRITING IN ENGLISH**, YOU MUST BRING AN INTERPRETER WITH YOU TO YOUR APPOINTMENTS. (PLEASE BE AWARE THAT YOUR INTERPRETER MUST PROVIDE THEIR CURRENT CONTACT INFORMATION AND A FORM OF VALID IDENTIFICATION FOR IMMIGRATION)
  INITIAL: _____

- IF YOU HAVE AN "A NUMBER OR ALIEN REGISTRATION NUMBER" YOU ARE RESPONSIBLE FOR BRINGING THIS NUMBER WITH YOU THE DAY OF YOUR APPOINTMENT. YOUR I-693 FORMS REQUEST THIS NUMBER, IF YOU DO NOT HAVE ONE ASSIGNED TO YOU YET, THIS DOES NOT APPLY TO YOU.
  INITIAL: _____

- ONCE YOUR APPOINTMENT HAS BEEN SET WITH OUR OFFICE, PLEASE BE AWARE THESE APPOINTMENTS TAKE TIME AND ACCURACY. IF YOU NEED TO RESCHEDULE OR CANCEL YOU MUST GIVE US A 24-48 HOUR NOTICE. LATE NOTIFICATIONS, CANCELLATIONS, OR MISSED APPOINTMENTS WILL BE CHARGED A 25$ FEE.
  INITIAL: _____

- PLEASE BE AWARE THAT IMMIGRATION REQUIREMENTS CAN CHANGE AT ANY GIVEN MOMENT AND THIS IS NOT AT FAULT OF PRONTO MEDICAL CARE, WE ARE REQUIRED TO COMPLY WITH ALL THE REQUIRMENTS OF USCIS ASSIGNED TO THE CIVIL SURGEONS AND OUR OFFICE.
  INITIAL:_____

  PATIENT'S PRINTED NAME: _____
  NURSE'S SIGNATURE: _____DATE: _____

By signing this you agree to the terms and conditions by our office "Pronto Medical Care" for the policy requirements for U.S Citizenship and Immigration Services

PRONTO MEDICAL CARE

Applicant's Information

First Name:_____ Last Name(s):_____ (M.I)_____

Address:_____

City, State:_____Zip Code:_____ Sex: Female or Male

Date of Birth:_____Home Phone:_____Mobile Phone:_____

Are you Single/Married/Divorced/Widowed/Separated? _____

Country of Nationality? _____ Birth Town/City/Village? _____

Emergency Contact

First Name:_____ Last Name(s):_____ (M.I)_____

Phone Number:_____ Relation to Patient:_____

Translator's Information (If Applicable)

First Name:_____ Last Name(s):_____ (M.I)_____

Address:_____

City, State:_____Zip Code:_____ Sex: Female or Male

Date of Birth:_____Home Phone:_____Mobile Phone:_____

PMC Staff Signature:_____ Date Completed:_____

First Name:_____ Last Name(s):_____ (M.I)_____

Do you have/had any Chronic Medical Conditions? If so please list:_____

_____

Do you have/had any history of Mental Illness or Disabilities? If so please list:_____

_____

Any Surgical History/Hospitalizations? If so please list:_____

_____

Any Known Drug Allergies? If so please list: _____

_____

Any Known History of HIV, STD's, Syphilis, or Tuberculosis? If so please list:_____

_____

Any Known History of Depression or Harmful Behavior?_____

Do you use Tobacco? If so, please specify type and frequency:_____

Do you use Alcohol? (Circle Response) Never Rarely Moderate Daily

Do you use any Recreational Drugs? If so, please specify:_____

_____

If you take any medications please list the (Name of the medication, dosage, and frequency):_____

_____

_____

_____

_____

_____

PMC Staff Signature:_____ Date Completed:_____