Please make sure your Handwriting is legible for our front staff to read and input into our systems

PATIENT'S PERSONAL INFORMATION
FIRST NAME:
LAST NAME:
MIDDLE NAME:
DATE OF BIRTH:
SOCIAL SECURITY NUMBER:
GENDER: (please circle): MALE or FEMALE
ADDRESS 1:
ADDRESS 2:
CITY: STATE: ZIP:
HOME PHONE: CELL PHONE:
EMAIL:
Parent/Guardian Information (Only if patient is under 18)
PARENT/GUARDIAN FIRST AND LAST NAME:
PARENT/GUARDIAN DOB: SOCIAL SECURITY NUMBER:
PARENT/GUARDIAN ADDRESS 1:
PARENT/GUARDIAN ADDRES 2:
GUARDIAN CITY: STATE: ZIP:
GUARDIAN HOME PHONE:
EMERGENCY CONTACT NAME:
EMERGENCY CONTACT RELATION TO PATIENT:
EMERGENCY PHONE 1:
PATIENT MARITAL STATUS: CHILD SINGLE MARRIED WIDOWED SEPARATED
EMPLOYER OF PATIENT:
PATIENT EMPLOYMENT STATUS: FULL TIME PART TIME RETIRED DISABLED
STUDENT STATUS: FULL TIME or PART TIME
INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER:
ID/POLICY NUMBER:
GROUP NUMBER:
POLICY HOLDER'S NAME:
POLICY HOLDER'S DATE OF BIRTH:
POLICY HOLDER'S SOCIAL SECURITY NUMBER:
POLICY HOLDER'S ADDRESS:
CITY: STATE: ZIP:
POLICY HOLDER'S EMPLOYER AND STATUS: FULL TIME PART TIME RETIRED DISABLED
SECONDARY INSURANCE CARRIER:
ID/POLICY NUMBER:
GROUP NUMBER:
POLICY HOLDER'S NAME:
POLICY HOLDER'S DATE OF BIRTH:
POLICY HOLDER'S SOCIAL SECURITY NUMBER:
POLICY HOLDER'S EMPLOYER:
POLICY HOLDER'S EMPLOYMENT STATUS: FULL TIME PART TIME RETIRED DISABLED
WORKER'S COMPENSATION: WERE YOU INJURED ON THE JOB? _____ HAVE YOU INFORMED YOUR EMPLOYER?_____ DATE OF ORIGINAL INJURY:_____
INTERPRETATION REQUIRED (please circle): YES or NO
HAVE YOU BEEN OUT OF THE COUNTRY IN LAST 30 DAYS: _____
HOW DID YOU HEAR ABOUT US? (please circle) RADIO FLYER GOOGLE FAMILY/FRIEND FACEBOOK TV OTHER: PLEASE LIST:

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the physician, but is usually not designed to pay the entire fee. Because insurance companies vary in the amount they will pay for various services, it is ultimately your responsibility to pay the portion of the bill not paid by your insurance company, unless otherwise restricted by law or an agreement we might have made with the insurer. In the case that your account becomes delinquent, and placed with a collections agency, a flat fee of $50 will be added to any delinquent balance. WE ARE AN URGENT CARE CENTER AND ADDITIONAL FEES MAY APPLY THAT YOU WOULD NORMALLY NOT INCUR AT YOUR PRIMARY CARE/PHYSICIAN'S OFFICE. I authorize any holder of medical or other information about me to release the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carrier or any commercial insurance company, any information needed for this or related Medicare/Medicaid claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.
I RECEIVED NOTICE OF THIS ORGANIZATION'S PRIVACY PRACTICES.

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____