

## Patient Information

Thank you for choosing our office! In order to serve you properly, we need the following information

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Primary Care Physician: \_\_\_\_\_ **IS THIS RELATED TO:**  
**Work Injury: Y/N**  
**Motor Vehicle Accident: Y/N**

### Patient:

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ MI: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Marital Status (please circle) S M D W SS#: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: M/F

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employee Status (Please Circle) FT/ PT/ Retired/ Not Employed Employer: \_\_\_\_\_

Home (\_\_\_\_) \_\_\_\_-\_\_\_\_-\_\_\_\_ Work (\_\_\_\_) \_\_\_\_-\_\_\_\_-\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_-\_\_\_\_-\_\_\_\_

### Notify In Case of Emergency:

Relationship: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home (\_\_\_\_) \_\_\_\_-\_\_\_\_-\_\_\_\_ Work (\_\_\_\_) \_\_\_\_-\_\_\_\_-\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_-\_\_\_\_-\_\_\_\_

### Primary Policy Holder's Information/ Responsible Party:

Policy Holder (Name): \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Policy Holder's DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Policy Holder's SSN: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer: \_\_\_\_\_ Employer Status (please circle) FT/ PT/ Retired / NA

Work (\_\_\_\_) \_\_\_\_-\_\_\_\_-\_\_\_\_ Insurance Company: \_\_\_\_\_

### Additional Insurance Information (Secondary Insurance)

Policy Holder (Name): \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Policy Holder's DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Policy Holder's SSN: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer: \_\_\_\_\_ Employer Status (please circle) FT/ PT/ Retired / NA

Work (\_\_\_\_) \_\_\_\_-\_\_\_\_-\_\_\_\_ Insurance Company: \_\_\_\_\_

I consent to treatment for myself or above minor child, I understand that the examination and/ore medical treatment I will receive is NOT intended to replace complete medical care by my personal primary care physician. I am aware that I will be responsible for co-payment or full payment at the time of service. Any pre-certification requirement that my insurance company requires is my responsibility to make. Furthermore, I allow the release to my insurance company treatment and billing information, as requested, to process my claim. I allow the Urgent Care Center to accept payments made by my insurance company on my behalf. I understand that by my lack of payment or if my insurance denies payment, I am responsible for payment in full for services rendered. My failure to pay may result in collection proceedings and/or late fees. In addition, I authorize the release to my primary care physician or specialty referral, any and call information related to my treatment at this clinic.

\_\_\_\_\_  
**(Signature of patient or parent/guardian if minor)** Date: \_\_\_\_/\_\_\_\_/\_\_\_\_