4906 Ambassador Caffery Parkway
Bldg. C, Suite 350
Lafayette, LA 70508
(337) 981-4675

Acadiana Urgent Care Center

PATIENT INFORMATION
(Patient's name as it appears on the insurance policy – no nicknames)

First Name:________________________ Last Name: ________________________ MI: ____ DOB: ___/___/___

Gender: M / F SSN: ______-______-_________ Home Phone: (_____) ______-__________

Mailing Address: Street: ____________________________________ Apt _____ Cell Phone: (____) _____-______

City: ______________________________ State: ______ Zip: _________ Email: __________________@____

Employer: ____ Employer Phone: (_____) ____-_________

Pref. Language: ______________________ Race: Amer. Indian / Asian / African Amer. / Native Hawaiian/ White

Ethnicity: Hispanic or Latino / Not Hispanic or Latin

Emergency Contact Name: ______________________ Phone: (____) _____-_______ Relationship: __________

Chose clinic because/Referred to by…? ☐ Dr. _______________ ☐ Insurance Plan ☐ Billboard Sign
☐ Family/Friend ☐ Saw on TV ☐ Close to home/work ☐ Web Search ☐ Other __________

INSURANCE

Ins. Company: ________________________ Member #: _____________________ Group #:_______________

Address: ____ Effective Date: ___/___/___

Policy Holder Information/Responsible Party

Relationship to Insured: _______________ Name: _________________________________ M / F

DOB: ___/___/___ SSN: _____-______-________ Home Phone: (____) ____-_________

Address (if different from above): ___________________________ Cell Phone (____) ______-______

Email: _______________@____ Employer: _______________ Status: FT / PT / Retired / Unemployed

Additional Insurance Information (Secondary Insurance):

Ins. Company: ____________________________ Member #: _________________ Group #:_______________

Address: ____ Effective Date: ___/___/___

Relationship to Insured: _________________________ Name: __________________________________ M / F

DOB: ___/___/___ SSN: _____-______-________ Home Phone: (____) ____-_________

Address (if different from above): ___________________________________ Cell Phone (____) _____-______

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. I am aware that I will be responsible to co-payment, deductible, co-insurance or full payment at the time of service. Any pre-certification requirements that my insurance company requires is my responsibility to make. Furthermore, I allow Acadiana Urgent Care (AUC) to accept assigned payments made by my insurance company on my behalf. I understand that by my lack of payment in full or if my insurance denies payment, I am responsibly for payment in full for services rendered. My failure to pay may result in collection proceedings and/or late fees. In addition, I authorize AUC to release to my primary care physician or specialty referral, any and all information related to my treatment at this clinic.

Patient Signature (Parent if a minor) ____ Date ____/____/__

WE DO NOT SEE MOTOR VEHICLE ACCIDENTS