First Med
URGENT CARE

PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL

DATE OF BIRTH	SEX ☐M ☐F	SSN

MAILING ADDRESS	APT. #	CITY	STATE	ZIP

EMAIL	PRIMARY CARE PHYSICIAN

LANGUAGE PREFERRED	RACE	ETHNICITY

HOME PHONE	CELL PHONE	OTHER PHONE

EMERGENCY CONTACT NAME	RELATIONSHIP	ADDRESS

EMERGENCY CONTACT PHONE	GUARANTOR	GUARANTOR ADDRESS (If different than patient)

PREFERRED METHOD OF CONTACT? ☐PHONE ☐EMAIL ☐MAIL **MAY WE LEAVE A MESSAGE ON YOUR ANSWERING MACHINE?** ☐YES ☐NO

PAYMENT: ☐CASH ☐CHECK ☐CREDIT CARD **FINANCIALLY RESPONSIBLE PARTY:** ☐PATIENT ☐FATHER ☐MOTHER ☐SPOUSE ☐OTHER_____

REASON FOR VISIT _____ **WORK RELATED?** ☐YES ☐NO
(List Symptoms)

ARE YOU OR IS THERE A POSSIBILITY YOU COULD BE PREGNANT? ☐YES ☐NO

HOW DID YOU HEAR ABOUT US?

☐ Employer ☐ Google ☐ Mailer ☐ Personal Referral ☐ Road/Building sign ☐ Social Media ☐ Website ☐ Existing Patient

PRIMARY INSURANCE POLICY HOLDER

POLICY HOLDER'S NAME	SSN	DOB

INSURANCE NAME	INSURANCE I.D. #

GROUP #	ADDRESS IF DIFFERENT THAN PATIENT'S	RELATIONSHIP TO POLICY HOLDER

SECONDARY INSURANCE POLICY HOLDER (if applicable)

POLICY HOLDER'S NAME	SSN	DOB

INSURANCE NAME	INSURANCE I.D. #

GROUP #	ADDRESS IF DIFFERENT THAN PATIENT'S	RELATIONSHIP TO POLICY HOLDER

PLEASE READ AND SIGN

- *I UNDERSTAND THAT I AM RESPONSIBLE FOR THE PAYMENT OF ANY SERVICES RENDERED AT TIME OF VISIT.*
  Please note: You may incur separate charges for Laboratory and Orthopedic Services.
- *I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES THAT ARE NOT COVERED BY MY INSURANCE PLAN, INCLUDING MEDICARE.*
- *I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN FOR SERVICES RENDERED.*
- *I AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.*

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: A DETAIL OF YOUR RIGHTS AND HOW YOUR MEDICAL INFORMATION WILL BE USED AND DISCLOSED IS SET FORTH IN THE NOTICE OF PRIVACY PRACTICES. A COPY HAS BEEN FURNISHED TO ME AND IS POSTED IN THE CLINIC.

PATIENT SIGNATURE _____ *DATE* _____