REASON FOR TODAYS VISIT _____

How did you hear about us? ☐ **Google** ☐ **Friend** ☐ **Drive by** ☐ **Yelp** ☐ **Dr** ☐ **Other**_____

Patient Name: Last _____ **First**_____

Date of Birth____/____/_____ **Social Security:** _____-___-_____

Address_____

City_____ **State**_____ **Zip Code**_____

Phone: Home_____ **Work**_____ **Cell**_____

Can we leave a message on your phone ☐ **Yes** ☐ **No?**

Marital Status: ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced**

Your Employer: _____

Preferred language if other than English: _____

Emergency contact name: _____

Emergency contact phone: _____ **Relationship:** _____

E-Mail Address: _____

Do You Have a Primary Care Physician: ☐ **YES** ☐ **NO?**

Physician Name: First_____ **Last**_____

Phone_____ **Fax**_____ **City**_____ **State**_____

Fax a copy of today's visit to my doctor: □ **Yes** □ **NO**

☐ **I authorize PrimeCare Urgent Care to release my medical information to the persons or work place listed below:**

_____

Insurance Carrier_____

Insured Subscriber Name_____

Date of Birth_____ **Relationship**_____

Insurance ID#_____ **Group#**_____

Insurance Carrier

Secondary Insurance ID#_____ **Group#**_____

Guarantor Name (If other than yourself) _____

I authorize PrimeCare Urgent Care to provide treatment to my legal dependent or myself.

_____ **(Patient/Guardian Initials)**

****Notice of Privacy Practices – Patient Acknowledgement**

Your name and signature below indicate that you have received/been offered a copy of PrimeCare Urgent Care Notice of Privacy Practices.

****Please note that services you receive on today's visit may not be covered by your insurance carrier. This includes charges from our office and/or separate charges for Laboratory Testing. You will be held responsible for payment if your insurance carrier does not cover these charges.**

IS THIS A WORK RELATED OR AUTO ACCIDENT? □**YES** □**NO** (***If yes, see backside for more info***)

Patient/Guardian Signature_____

Date ___/___/_____

AUTO RELATED INJURY

Patient Name_____ **ID Number**_____

Name of Insurance Company_____

Name of Adjuster_____

Phone Number_____ **Fax Number**_____

Claim Number_____

Date of Incident_____

WORKMAN'S COMP OR OCCUPATIONAL MEDICINE

Name of Company_____

Address_____

City_____ **State**_____ **Zip Code**_____

Supervisor Name_____

Phone Number_____ **Fax Number**_____

Date of Incident_____ **Insurance Information:** _____