PATIENT INTAKE FORM

ATTENTION: IF YOU ARE EXPERIENCING CHEST PAIN/DISCOMFORT. PLEASE ALERT THE STAFF IMMEDIATELY. THANK YOU.

○ NEW PATIENT ○ EXISTING PATIENT

Name: _____ _____ ____ D.O.B: _____ Soc. Sec. #: _____
Last Name First Name Initial

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work/Mobile Phone: _____ Email: _____

Sex: ○ Male ○ Female Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed

In case of emergency, who should be notified? _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Preferred Pharmacy: _____ Cross Streets/Phone #: _____

PRIMARY INSURANCE

Person Responsible for Account: _____ D.O.B: _____

Relationship to Patient: _____

Address(if different from patient's): _____ Phone: _____

City: _____ State: _____ Zip: _____

Person Responsible Employed by: _____ Occupation: _____

Business Address: _____ Phone: _____

Insurance Company: _____ **Ins. ID No:** _____

ASSIGNMENT AND RELEASE

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I acknowledge that I am financially responsible for all charges whether or not they are covered by insurance. I also understand that all charges are to be paid at the time of the visit unless other arrangements have been made prior to my scheduled appointment. Payment for all dispensary items is due at the time of visit. I authorize Premium Urgent Care to release any information required to process my claims.

Patient Signature: _____ Date: _____

Responsible Party Signature: _____ Date: _____

What brings you to the clinic today? _____

_____

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