

Welcome!

Please fill out this one page intake form.
PATIENT INFORMATION

Name: _____ Gender: F M

Date: _____ Date of Birth: _____

Local Home Phone #: _____ Cell #: _____

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

Emergency contact name: _____ Phone #: _____

Please be as specific as possible as to how you found us:

Free Antibiotics Billboard Facebook/Instagram Online Search

Flags outside Reviews Marie (Marketing Rep)

Employer _____ Other _____

Friends and Family. To improve our marketing who should we thank for referring you?

MEDICAL RECORDS

***Required, please write your email to access your electronic medical records:**

Email: _____

REASON FOR YOUR VISIT

Please list your health concern: _____

Worker's Comp Auto Accident Currently pregnant? How far along? _____

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Doctors Urgent Care for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

Fees incurred in Collection or Litigation of any unpaid balances will become the responsibility of the patient or guarantor. I irrevocably assign my benefits to Doctor's Urgent Care including the right to sue my insurance company for denials or reductions. I authorize the above medical provider to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party: _____ **Date:** _____

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Doctors Urgent Care's HIPAA form: "Notice of Privacy Practices" which has been updated as of September 2013.

Signature: _____ **Date:** _____

OR

I refuse to sign this because: _____