Welcome!

Please take a few minutes to fill out the following information.

PATIENT INFORMATION

Name: _____ Gender: F M

Date: _____ Date of Birth: _____

Local Home Phone #: _____ Cell #: _____

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

Emergency contact name: _____ Phone #: _____

To improve our marketing efforts, who should we thank for referring you?
Please be as specific as possible:

☐ Drive-By ☐ Billboard ☐ Friends/Family _____ ☐ Paper Phone Book

☐ Internet (site) _____ ☐ Pharmacy (name) _____ ☐ Doctor's Office (name) _____

☐ Marketing Representative _____ ☐ Other _____

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: _____

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 of guarantor. I irrevocably assign my benefits to Doctor's Urgent Care including the right to sue my insurance company for denials or reductions. ***I also agree that if a referral is needed by my primary doctor, it is my responsibility to obtain it.*** 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: _____