PALM COAST URGENT CARE

DATE_____

PATIENT NAME_____MARITAL STATUS M__S__D__W__O__

ADDRESS_____CITY_____STATE_____ZIP_____

MAILING ADRESS_____SOCIAL SECURITY #_____

IF YOU LIVE OUT OF STATE PLEASE PROVIDE US WITH A LOCAL ADDRESS AND CONTACT NUMBER_____

HOME PHONE_____**CELL PHONE**_____

E-Mail Address: _____

DATE OF BIRTH____/____/_____ AGE_____ SEX M__F__

EMPLOYER_____WORK PHONE_____

WHAT IS THE NATURE OF YOUR ILLNESS TODAY_____

WHAT LAB DO YOU USUALLY USE_____

EMERGENCY CONTACT NAME_____ PHONE_____

ADDRESS_____RELATIONSHIP_____

IS YOUR VISIT DUE TO A WORK RELATED OR MOTOR VEHICLE ACCIDENT?YES__NO__

INSURANCE INFORMATION
INSURANCE CO NAME_____ID#_____GROUP#_____

NAME OF POLICY HOLDER_____

POLICY HOLDER'S DOB_____ ADDRESS_____

OTHER INSURANCE_____ID#_____

RESPONSIBLE PARTY INFORMATION FOR MINORS

MOTHER'S NAME_____ADDRESS_____
EMPLOYER_____WORK PHONE_____HOME PHONE_____
FATHER'S NAME_____ADDRESS_____
EMPLOYER_____WORK PHONE_____HOME PHONE_____
MOTHER'S SSN_____FATHER'S SSN_____
MOTHER'S DOB_____FATHER'S DOB_____

HOW DID YOU HEAR ABOUT THIS FACILITY? _____
FOR INSURANCE PURPOSES I HEARBY AUTHORIZE THIS FACILITY TO TREAT ME AND RELEASE MY INFORMATION ACQUIRED IN THE COURSE OF MY TREATMENT AND AUTHROIZE ALL PAYMENTS TO BE MADE DIRECTLY TO **PALM COAST URGENT CARE**

SIGNATURE OF PATIENT OR GUARDIAN_____