PRIMECARE Urgent Care

Account NO:_____________

New Patient (   ) or update (   )

PLEASE PRINT ***Primary Care Physician :*** ***Pharmacy of choice:***

PATIENT INFORMATION

Name:____ Social Security#_______-_______-_______

Last First

Home Phone (   )_______-________ Cell Phone(   )________-_______ Birth date: ____/_______/_______ Age______ Sex M___F___

Home Address:____City:________________State:_______Zip:___________

Winter Visitor: Summer Address____City:_________________State:_______Zip:___________

Mailing Address (if PO Box required)____City:_________________State:_________Zip:_________

Email Address:____

PATIENT EMPLOYER

Employer:____ Dept:____

Address____

Street City State Zip

Phone # (   )_____________-_____________

GUARANTOR INFORMATION

GUARANTOR EMPLOYER

Name:____ Name:___________________________________

Address:_______________________________________ Address:_________________________________

____ ___________________________________

City State Zip City State Zip

Phone # (   )_________-___________ Phone# (   )__________-___________

Social Security #__________/_______/________ DOB: ______/_____/______ Relationship to Patient:______________________________

Emergency Contact:_____________________________________ **Phone (   )__________-________ Relationship:**_____________________

Last **First**

REASON FOR VISIT:____

Work Related: ______Yes ______No Date of Injury _________/________/__________

****If yes, please request a Pink Form from the Receptionist. This must be completed in order to bill your Industrial carrier.***

INSURANCE INFORMATION

(Office Staff Use Only)

PRIMARY :____ID#______________________________ Verified: ___________

POLICY HOLDER:____DOB:_____________________________ Unable to Verify: ____

SOCIAL SECURITY#____EMPLOYER:__________________________ Source Used: _______

SECONDARY:____ID#______________________________ _________________

POLICY HOLDER:____DOB______________________________ _________________

SOCIAL SECURITY #_______________________________________EMPLOYER:___________________________ _________________

Treatment Consent and Assignment of Benefits-Financial Arrangement

I authorize medical evaluation and treatment as deemed necessary and appropriate by PrimeCare Clinics medical providers. I hereby give authorization for payment of insurance benefits to be made directly to PrimeCare Clinics and any assisting physicians and or billing agents for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I agree that a photocopy of this agreement shall be as valid as the original.
I AM AWARE THAT THESE CHARGES ARE ESTIMATES ONLY AND THAT I MAY RECEIVE ADDITIONAL BILLINGS.

Please initial

- **I have received, read and understood the HIPPA PRIVACY RIGHTS______________**
- **I have received, read and understood the Patient Rights & Responsibilities____________**

Patient, Parent, or Guardian____________________________________Date________/_____/_______

Signature__________________________________