EAST SIDE URGENT CARE – PATIENT DEMOGRAPHIC SHEET

NAME ____ DOB ______/______/______

ADDRESS ____

CITY ______________________________ STATE __________ ZIP CODE ___________________

LEGAL GUARDIAN IF UNDER 18 ____

SSN _________________________ MARITAL STATUS MARRIED SINGLE

HOME PHONE _____________________ CELL PHONE _______________________

EMAIL ADDRESS ____

EMERENCY CONTACT NAME _______________________________ PHONE _______________

POLICY HOLDER FOR INSURANCE SELF SPOUSE PARENT

NAME OF POLICY HOLDER IF NOT YOU ____

REASON FOR TODAY'S VISIT ____

BILLING POLICY: The goal of our staff is to provide the best professional care to all of our patients. Although we make every effort to assist patients with questions regarding their insurance, it is ultimately the responsibility of the patient to be familiar with his/her insurance policies. We therefore encourage patients to contact their insurance company prior to being seen to assure their visit, lab work or referrals to specialists will be covered by their plan. If for any reason the insurance company denies the services, the patient is responsible for the charges submitted to the carrier. I hereby authorize the direct payment of medical benefits to **East Side Urgent Care** for services rendered. I understand that I am financially responsible for any balances not covered by my insurance plan.

Signature ____ Date _______/______/______

Printed Name ____

Release of Information: I authorize the release of all medical information to **East Side Urgent Care** from any prior PCP, laboratory, therapist, specialist or medical facility while under their care.

Signature ____ Date _______/______/______

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your private health information. Please sign to acknowledge receipt of this notice.

Signature ____ Date _______/______/______

Please print your name here