



Welcome to our office, thank you for choosing us.

In order to serve you properly we will need the following information filled out completely. (Please print.)

PATIENT INFORMATION:

LAST NAME: FIRST NAME MI:

ADDRESS: APT. #: CITY:

STATE: ZIP: HOME PHONE: ()

PERSONAL E-MAIL ADDRESS:

WORK PHONE: () CELL: () D.O.B.:

SSN#: AGE: MALE FEMALE

MARITAL STATUS: MARRIED SINGLE WIDOWED DIVORCED SEPARATED

EMPLOYER: WORK PHONE: ()

EMPLOYER ADDRESS: CITY: STATE: ZIP:

EMERGENCY CONTACT:

RELATIONSHIP: PHONE: ()

INSURANCE INFORMATION:

NAME OF INSURANCE:

ADDRESS: CITY: STATE: ZIP:

POLICY / ID # GROUP #: Co-PAY : \$

POLICY HOLDER NAME: RELATIONSHIP:

D.O.B.: SSN#: AGE: MALE FEMALE

ADDRESS (if different than patients)

CITY: STATE: ZIP: PHONE:

POLICY HOLDER'S EMPLOYER NAME: EMPLOYER PHONE:

ADDRESS: CITY: STATE: ZIP:

{ I (Patient) have been informed that my insurance is out of network. Pt's Initials }

Do you have a secondary insurance (check one) { YES { NO

If patient is a minor, who may authorize treatment?

Relationship: SS # of Guardian Phone: ()

Is Guardian address same as patient Yes / No (If No then we need Guardian to fill out separate information form)

Do you authorize this office to discuss your care or treatment with any party besides yourself: Yes/ No

Spouse Other

I hereby authorize Advanced Urgent Care to provide medical treatment and/or to release any information acquired in the course of my examination or treatment to referring physician (including your primary doctor) or insurance carrier listed above upon request.

AND

FINANCIAL AGREEMENT

I acknowledge full responsibility for all charges incurred, regardless of possible insurance coverage. I hereby authorize Advanced Urgent Care to obtain on my behalf, any insurance information covered by "The Privacy Act" from my insurance company(s) file(s). I hereby authorize payment directly to the physician(s) for medical and/or surgical benefits or auto accident. I FURTHER AGREE TO PAY 1.5% PER MONTH INTEREST FOR ANY OUTSTANDING BALANCES. IF THE ACCOUNT IS FORWARDED TO A COLLECTION AGENCY A 35% FEE WILL BE CHARGED, IN ADDITION TO ATTORNEY FEES, AND OTHER COLLECTION COSTS THAT MAY BE INCURRED TO ENFORCE COLLECTION OF ANY AMOUNTS OUTSTANDING. Balances of \$5.00 or less will not be billed but will remain on account for later collections.

Print Patient or Legal Guardian: Date:

Signature of Patient



or Legal Guardian: _____ Date: _____

GUARDIAN INFORMATION

FOR PATIENT: _____
INSERT PATIENT NAME ABOVE

Guardian Information

LAST NAME: _____ **FIRST NAME** _____ **MI:** _____

ADDRESS: _____ **APT.:** _____

CITY: _____ **STATE:** _____ **ZIP:** _____

HOME

PHONE: (____) _____ **WORK PHONE:** (____) _____ **CELL:** (____) _____

D.O.B.: _____ **SSN#:** _____ **AGE:** _____ **MALE** **FEMALE**

MARITAL STATUS: **MARRIED** **SINGLE** **WIDOWED** **DIVORCED** **SEPARATED**