ADVANCED
URGENT CARE
CENTER

PATIENT INFORMATION FORM

Patient's Full Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Number: _____ Cell Phone: _____

Sex: _____ Date of Birth: _____ SS#: _____

Patients Employer's Name: _____ Phone #: _____

Emergency Contact: _____

Relationship: _____ Phone #: _____

Primary Insurance Coverage

Insurance Company: _____

Name of Primary Insured: _____

Insured DOB: _____ Employer: _____

Insured SS #: _____ Relationship to Patient: _____

ID #: _____ Group #: _____

I authorize Advanced Urgent Care Center to release to my insurance carrier and/or their agents any information necessary to determine benefits payable for related services. I authorize the payment of medical benefits to Advanced Urgent Care Center. I understand that I am ultimately responsible for all services whether covered by insurance or not. I also authorize my physician, based on his/her discretion to access my chart for utilization management review.

Signature: _____ Date: _____