Health First
URGENT CARE

PATIENT INFORMATION

Name: _____ **Date:** _____/_____/_____
Last First MI

DOB: _____/_____/_____ **SSN:** _____-_____-_____ **Age:** _____ **Sex:** ☐ **M** ☐ **F**

Address: _____
Street Apt # City State Zip

Home Phone (____)_____ **Cell Phone** (____)_____ **Work Phone** (____)_____
☐ Yes, messages can be left at this number. ☐ Yes, messages can be left at this number. ☐ Yes, messages can be left at this number.

Which would you prefer we call? ☐ Home ☐ Cell ☐ Work **Email:**_____

Emergency Contact: _____
Name Phone Relationship

Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed**

If you would like to authorize Health First Urgent Care to release information regarding your medical care and/or laboratory results to someone in addition to yourself (spouse, parent, etc.) please list name below: If not, please check the box below:

☐ **Please do not disclose information to anyone but myself**

_____ _____
Name **Relationship**

PRIMARY INSURANCE INFORMATION

Insurance Company _____ Benefit Phone _____

Subsciber ID # _____ Group # _____

SECONDARY INSURANCE INFORMATION

Insurance Company _____ Benefit Phone _____

Subsciber ID # _____ Group # _____

INSURANCE POLICY HOLDER (IF DIFFERENT FROM PATIENT)

Print Name as it appears on your insurance card:

Name: _____ **DOB** _____/_____/_____
Last First MI

Address: _____
Street Apt # City State Zip

Contact Number (____)_____ **Relationship to Patient:** _____

I have read all of the above information and have completed it to the best of my knowledge. I will notify you of any changes in my health status or demographic information. I hereby authorize Health First Urgent Care to furnish information to insurance carriers concerning my medical status. I understand that I am responsible for any amount not covered by my insurance.

_____ _____
Signature of Patient/Guardian **Date**