PATIENT INFORMATION

Patient Last Name: ______________________________First: _______________________ MI: ____

Address: ______________________________ City_________________ State_____ Zip_________

Date of Birth:_______________ Social Security No.: _____/____/__________ Sex: □ M □ F

Home Phone: (_____)_______________ Cell:(_____)___________________ Email:_______________

Employer Name: ___________________________ Occupation: _____________________________

Employer Address:________________________ City________________ State_____ Zip_________

Employer Phone: (_____)________________

□ Married □ Divorced □ Widowed □ Single Spouse's Name:________________________

Referring Dr.:___________________________ Primary Care Dr: ____________________________

How did you hear about us?________________ Pharmacy name and number: __________________

INSURANCE INFORMATION

Insured Name: ______________________________ Insured Date of Birth: ____________________

Insured Social Security Number: ______/____/______ Insured Phone: (_____)__________________

Insured Employer Name: ___________________________Occupation: _______________________

Insured Employer Address: ____________________ City: ___________ State: _____Zip: ________

Insured Employer Phone Number: (_____)_____________

EMERGENCY CONTACT INFORMATION

First Emergency Contact: Name: ______________________ Phone Number: (____)_____________

Relationship To Patient: ____________________________

Second Emergency Contact: Name: ____________________ Phone Number: (____)________________

Relationship to Patient: ____________________________

SIGNATURE PLEASE – ASSIGNMENT AND RELEASE

I hereby authorize examination and any other medical services deemed necessary. I authorize Urgent Care of Madison to forward the results of any tests and/or medical services to medical facilities (primary care providers, referring physicians, hospitals, etc) or insurance company/ companies including Worker's Compensation that they may require concerning my case. I hereby authorize and request my insurance company/companies to pay directly to Urgent Care of Madison the amount due to them in my pending claim for medical or surgical treatment services. I understand that my insurance is a contract between myself and my insurance company, not between the insurance company and the provider. I understand that any balance remaining after my insurance pays or denies payment is my responsibility. Interest may be charged on accounts that are past due by 90 days or more at a rate of 1 1/2% per month or 18% per year. I agree my records may be used and reviewed during quality assurance programs.
I hereby release Urgent Care of Madison from liability for any loss or damage to property which is brought to or kept in the facility during my treatment.

DATE: _______________ **SIGNATURE:** ____________________________________