

PATIENT INFORMATION FORM

Patient Name		Social Security Number	
Date of Birth	Marital Status S M D W P	Address	
Home Phone	Ok to leave message? Yes No	City	State Zip Code
Email Address		Employer's Name/Occupation	
Mobile Phone or Pager	Work Phone	Ok to leave message? Yes No	
Emergency Contact	Relationship	Emergency Contact Phone	
Primary Care Physician	Insurance		
Pharmacy with two cross streets	Name of Insurance co. _____		
How were you referred to our practice? <input type="checkbox"/> Newspaper <input type="checkbox"/> Friend <input type="checkbox"/> Internet <input type="checkbox"/> Sign/Drive Bye <input type="checkbox"/> Yellow pages <input type="checkbox"/> Other _____	ID# _____		
	Group# _____		
	Phone# _____		

Parent/Guardian or Primary Insured Info (if patient is a minor or is not the primary insured)

Parent/Guardian or Primary Insured Name		Social Security Number	
Date of Birth	Relationship to patient	Address (if different from above)	
Home Phone		City	State Zip Code
Work Phone	Employer's Name		

-----Please read below and sign-----

Benefits Assignment

I hereby authorize the assignment of benefits (payments) directly to Apex Urgent Care Clinic for all my insurance claims related to services received. I agree to pay any and all charges that exceed, or are not covered by my insurance

Signature of Responsible Party: _____ Date: _____

Record Release

I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

Signature of Responsible Party: _____ Date: _____