PATIENT INFORMATION E-mail address: _____

Name:_____
(First) (Middle) (Last)

Address:_____
(Street Address) (City) (State) (Zip Code)

Home phone: (_____)_____ Work phone: (_____)_____ Cell Phone: (_____)_____

Employer Name / Address:_____ Occupation:_____

Primary Language _____ Ethnicity _____

Gender: □ Male □ Female Date of Birth:_____ Age: _____ SS#_____

□ Single □ Married □ Widowed □ Separated □ Divorced

EMERGENCY CONTACT_____
(Name)
_____(_____)_____
Relationship to patient phone number

Reason for Visit:_____

How did you hear about us?

□ Previous Patient □ Word of Mouth □ Facility Signage
□ Internet Search □ Print Advertising
□ Phone Book/Yellow Pages □ School/Daycare: _____
□ Employer: _____ □ Physician Referral: _____
□ Pharmacy: _____ □ Other _____

PRIMARY CARE PHYSICIAN

Name:_____ Phone: (_____)_____

PHARMACY

Name:_____ Phone: (_____)_____

PRIMARY INSURANCE INFORMATION (only if card is NOT present in clinic)

Insurance Company:_____

Type: □ HMO/PPO □ Medicare □ Medicaid/AHCCCS □ Tricare □ Other _____

ID / Policy #_____ Group #:_____

Copay Amount:_____ Effective Date:_____

Secondary Insurance? □ Yes □ No Name:_____

Continue to Back Side →

Guarantor for Minor: Authorization to Treat Minor

Full Name:_____ Date of Birth:_____

Social Security #:_____ Relationship to Patient:_____

Permanent Address:_____
(Street) (City) (State) (Zip)

Primary Phone #:_____ Secondary Phone #:_____

Parent or Legal Guardian Signature:_____

Consent for Treatment:
I consent to the performance of all routine medical care and treatment (e.g. tests, therapy, medical treatment or procedures, etc.) which may be performed as deemed necessary by and under the general and special instructions of the physician and/or authorized health care providers of Elizabeth Lake Urgent Care.

Release of Information
I agree that, to the extent necessary to determine liability for payment and to obtain reimbursement, or as otherwise permitted or required by law, Elizabeth Lake Urgent Care may disclose any portion of my/the patient's medical records including but not limited to, information about my/the patient's diagnosis and/or treatment relating to medical, mental health, developmental disability, and/or substance abuse treatment to any person, regulatory or government agency, or corporation including, but not limited to, insurance companies, or health care service plans which are, or may be liable for, all or any portion of Elizabeth Lake Urgent Care's charges. To ensure coordination of my/the patient's ongoing care and treatment, I also consent to the release of any medical information to y/the patient's primary care physician or health care provider and any consulting physicians or health care providers participating in my/the patient's care.

Privacy Notice: HIPAA
By signing this section, you acknowledge receipt of Notice of Privacy Practices of Elizabeth Lake Urgent Care.
By signing this section, you also agree to the two paragraphs above which explain how we may use or disclose your protected health information. We encourage you to read it in full.

Printed Name of Patient/Guardian:_____

Signature:_____ **Date:**_____

Authorization:
The undersigned certifies that the patient has read the information noted above and has been given the opportunity to have any questions answered fully and to his/her satisfaction, and has the option to receive a copy of this agreement upon request. The undersigned further certifies that the patient is 1) the patient or 2) the patient's legal representative or 3) is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

Signature of Patient or Guardian:_____ **Date:**_____