PATIENT INFORMATION

NAME FIRST ____________ MI ____________ LAST ____________

ADDRESS ____

CITY ____________ STATE ____________ ZIP ____________

EMAIL ____________ PHONE # ____________ CELL # ____________

SOCIAL SECURITY # ____________ PATIENTS DOB ____________ DL # ____________

REFERED BY:

- ○ PHYSICIAN
- ○ PHONE BOOK
- ○ FRIEND / RELATIVE
- ○ INSURANCE
- ○ SIGN
- ○ MAIL

OTHER: ____

PRIMARY PHYSICIAN: ____

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT FROM PATIENT)

NAME FIRST ____________ MI ____________ LAST ____________

ADDRESS ____________ APT # ____________ PHONE ____________

CITY ____________ STATE ____________ ZIP ____________

SOCIAL SECURITY # ____________ DOB ____________ DL # ____________

INSURANCE INFORMATION

NAME OF PRIMARY CARD HOLDER ____________ RELATIONSHIP TO INSURED ____________

SOCIAL SECURITY # ____________ DOB ____________

NAME OF INSURANCE PLAN ____________

MEMBER # ____________ GROUP # ____________

I request payment of authorized insurance/medicare benefits be made on my behalf to Westbank Urgent Care for any services furnished me by that provider. I authorize any holder of medical information about me release to my insurance carrier/CMS (centers for Medicare & Medicaid service) and its agents any information needed to determine these benefits payable for related services. I understand I am financially responsible for any benefits not covered by my insurance.

SIGNATURE ____________ DATE ____________