

WESTON URGENT CARE CENTER
PATIENT INFORMATION
PLEASE COMPLETE ALL INFORMATION PRIOR TO TURNING IN FORM

Patient information

Patient Name: _____ Social Security #: _____

Have you ever been treated at the Urgent Care Center before? YES / NO (If yes see below)

Do you have advance directive? YES / NO If yes, can we get a copy? _____ (optional)

Local Address: _____ City, St, Zip: _____

Out of State Address: _____ City, St, Zip: _____

Phone Number: () _____ - _____ Birth Date: ____/____/____

Marital Status: _____ Race: _____ Sex: Male / Female

Guarantor Information (must be completed if patient is not 18 years of age)

Guarantor Name: _____ Relationship to Patient: _____

Address: _____ City, St, Zip: _____

Phone Number: () _____ - _____

Guarantor Social Security #: _____ Guarantor Birth Date: ____/____/____

Patient Employment Information

Name of Employer: _____ Phone Number: () _____ - _____

Employer Address: _____ City, St, Zip: _____

Occupation: _____

Reason for Visit

Why are you here today?: _____

Were you treated previously at this facility for the same reason? YES / NO

Is this visit Accident or Injury Related?: YES / NO (If yes see below)

Date it occurred: ____/____/____ Time it occurred: _____ AM / PM

Where it occurred: _____ How it occurred: _____

If work related injury has the employer been informed? YES / NO

Insurance Information (please provide insurance card)

Insurance Plan Name: _____

Name of Insured: _____ Relationship to Patient: _____

Insured policy ID #: _____ Insured Group #: _____

Insured Social Security #: _____ Insured Birth Date: ____/____/____

Effective date of insurance: ____/____/____

I verify that the above information is true and accurate:

Patient or Guarantor Signature

Date: ____/____/____