Immediate Health Urgent Cares

Patient Information

Reason for Today's visit: _____

Patient Name: _____ Gender:_____

Address: _____

City:_____ State:_____ Zip:_____

Preferred Phone #:_____ Alternate #:_____

Date of Birth:_____ Social Security #:_____

Marital Status: ( ) Single ( ) Married ( ) Other

Family/Referring Physician: _____

If Patient is a Minor

Parent or Guardian accompanying child:_____

Address if different than above: _____

Phone #:_____ Social Security #:_____ Date of Birth: _____

Emergency Contact Information:

Name:_____ Phone:_____

Relationship to patient:_____

Primary Insurance:_____

ID #:_____ Group #:_____

Insurance Claims Address:_____

City:_____ State:_____ Zip:_____

Person Responsible for Insurance:_____ Relationship to Patient:_____

Date of Birth:_____ Soc. Sec.#_____ Phone: _____

Address, if different than patient: _____

Secondary Insurance:_____

ID #:_____ Group #:_____

Insurance Claims Address:_____

City:_____ State:_____ Zip:_____

Person Responsible for Insurance:_____ Relationship to Patient:_____

Date of Birth:_____ Soc. Sec.#_____ Phone #:_____

Address, if different than patient: _____