777 URGENT CARE
7AM - 7PM - 7 DAYS A WEEK

NEW PATIENT INTAKE FORM

NAME: _____ DOB: _____ SEX: □ MALE □ FEMALE

E-MAIL:_____ MARITAL STATUS: _____

ADDRESS:_____ CITY, STATE, ZIP:_____

PHONE: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ □ HOME □ WORK □ CELL - CAN WE LEAVE A MESSAGE: □ YES □ NO

SOCIAL SECURITY #: _____ GUARANTOR: _____ □ SAME AS PATIENT

RELATIONSHIP: _____ DOB: ___/___/___

EMPLOYER: _____PHONE: (___ ___ ___) ___ ___ ___ - ___ ___ ___

ADDRESS:_____

EMERGENCY CONTACT NAME: _____ RELATIONSHIP: _____

PHONE: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

INSURANCE INFORMATION: PLEASE GIVE RECEPTIONIST YOUR INSURANCE CARD, IF YOU DON'T HAVE AN INSURANCE CARD PLEASE FILL OUT BELOW:

□ I AM SELF PAY

INSURANCE:_____ PHONE: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

ADDRESS:_____ ID#:_____

NAME OF INSURED: _____ RELATIONSHIP: _____ DOB OF INSURED: _____

SEX: □ MALE □ FEMALE

Assignment of Benefits I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Bridlewood Family Healthcare dba 777 Urgent Care for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by my insurance.

Authorization to Release Information I hereby authorize Bridlewood Family Healthcare dba 777 Urgent Care to (1) release any information necessary to insurance carriers regarding my illness and/or treatments: (2) process insurance claims generated in the course of examination or treatment: and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Bridlewood Family Healthcare dba 777 Urgent Care on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____ _____ ___/___/___

Parent/Responsible Party Signature (if Minor) **(Print Patient Name)** **Date**