

FOLSOM URGENT CARE

Reason for Visit: _____

Patient Information

Last Name: _____ First Name: _____

Social Security Number: _____ Date of Birth: _____ Sex: Male/Female

Address: _____ City: _____ State: _____

Zip Code: _____ Phone Number: _____ Cell Number: _____

E-mail Address: _____

Employer: _____ Phone Number: _____

Address: _____

Guarantor for Minor: Authorization to treat minor

Last Name: _____ First Name: _____

Social Security Number: _____ Date of Birth: _____ Sex: Male/Female

Address: _____ City: _____ State: _____

Zip Code: _____ Phone Number: _____ Relationship: _____

Signature of Parent or Legal Guardian: _____ **Date:** _____

Insurance Information

Name of Primary Insurance: _____ Policy Number: _____

Name of Primary Insured: _____ Date of Birth: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Phone Number: _____ Relationship: _____

Name of Secondary Insurance: _____ Policy Number: _____

Name of Primary Insured: _____ Date of Birth: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Phone Number: _____ Relationship: _____

Primary Care Physician

Name of Doctor: _____ Phone Number: _____

Location: _____ Fax Number: _____

Please complete the back of this form

FOLSOM URGENT CARE

Emergency Contact

Last Name: _____ First Name: _____

Phone Number: _____ Cell Number: _____ Relationship: _____

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 Folsom 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, Folsom Urgent Care may disclose any portion of my/the patient's medical records including but not limited to, information about patient's diagnosis and/or treatment relating to medical, mental health, developmental disability, and/or substance abuse treatment to any government agency or corporation including, but not limited to, insurance companies, employers, or health service plans to ensure coordination of my/the patient's ongoing care and treatment. I also release any medical information to the patient's primary care physician or any consulting physicians or health care providers participating in my/the patient's care.

Privacy Notice: HIPAA

By signing this section, you acknowledge understanding of the above Notice of Privacy Practices of Folsom Urgent Care provides and information about how we may use or disclose your protected health information. We encourage you read it fully.

Print name of Patient: _____

Print name of Person signing below: _____ **Relationship:** _____

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

Authorization

The undersigned certifies that he/she has read the information noted above and has been given the opportunity to have questions answered fully regarding the above information and to his/her satisfaction, and has the option to receive a copy of this agreement upon request. The undersigned further certifies that he/she is 1) the patient 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 accepts its terms.

Print name of Person signing below: _____ **Relationship:** _____

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

FOLSOM URGENT CARE

How did you hear about Folsom Urgent Care?

Monument Sign

Google/Yahoo Search

Yellow pages

Local News

Friend/Relative

Pocket Newspaper

Doctor/Insurance

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