



PATIENT INFORMATION

PATIENT NAME: _____ SEX: M _____ F _____
 ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
 DATE OF BIRTH: _____ AGE: _____ MARITAL STATUS: _____ S _____ M _____ D _____ W
 SOCIAL SECURITY #: _____ HOME PHONE #: _____
 EMAIL ADDRESS: _____ WORK PHONE #: _____
 EMPLOYER NAME: _____ CELL PHONE #: _____
 EMERGENCY CONTACT: _____ PHONE #: _____

INSURED PARTY INFORMATION

NAME: _____ DATE OF BIRTH: _____
 ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
 EMPLOYER NAME: _____
 ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
 SOCIAL SECURITY #: _____ HOME PHONE #: _____
 RELATIONSHIP TO PATIENT: _____

INSURANCE INFORMATION

PRIMARY PLAN NAME: _____
 ADDRESS TO MAIL CLAIMS: _____ CITY: _____ STATE: _____ ZIP: _____
 GROUP #: _____ POLICY OR SS#: _____
 SECONDARY PLAN NAME: _____
 ADDRESS TO MAIL CLAIMS: _____ CITY: _____ STATE: _____ ZIP: _____
 GROUP #: _____ POLICY OR SS#: _____

Payment in full is due at time of visit. We will be happy to file your insurance for reimbursement, if we are participating with the plan. It is your responsibility to be aware of coverage limits on your insurance plan. If you have any questions regarding your insurance coverage or payment, you must contact the insurance company directly.

AUTHORIZATION FOR TREATMENT: I consent to examination, treatment, and any procedures including emergency treatment deemed necessary and ordered by our physician and I am personally responsible for any charges.

AUTHORIZATION FOR INSURANCE: I authorize release of any information concerning myself or child to my insurance company regarding treatment for services rendered.

AUTHORIZATION FOR INSURANCE BENEFITS: I authorize my insurance company to send payment directly to Northside Urgent Care and Family Medicine LLC for services covered by my insurance plan.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE: I hereby acknowledge that Northside Urgent Care and Family Medicine LLC has provided me a copy of their Privacy Notice.

AUTHORIZATION TO CONTACT ME: I authorize Northside Urgent Care and Family Medicine LLC to contact me by either phone, electronic mail, or mail to provide a reminder appointment, gather demographic or insurance information, or to inform me of services or events offered at the facility.

SIGNED _____ DATE _____