DELTA URGENT CARE
Walk-in Clinic and Occupational Medicine

PATIENT INFORMATION

Name: Last _____ First _____ MI_____

Social Security # _____ Date of Birth: _____ Gender: ☐ Male ☐ Female

Race: _____ ☐ Hispanic ☐ Latino ☐ Non-Hispanic Preferred Language:_____

Address: _____

City: _____ State: _____ Zip: _____

Phone #_____ Cell #_____

Marital Status: _____ Patient Employer: _____

E-mail Address: _____

Emergency Contact Name: _____ Phone # _____

How did you hear about Delta Urgent Care?

☐ Friend ☐ Letter ☐ Mailer ☐ Newspaper ☐ Phonebook ☐ Insurance Directory ☐ Radio ☐ Relative
☐ Signage ☐ Work ☐ Internet ☐ Facebook ☐ Other

GUARANTOR/RESPONSIBLE PARTY (if patient is under 18)

Relationship to Patient: ☐ Mother ☐ Father ☐ Guardian ☐ Other_____

Name: Last _____ First _____ MI_____

Social Security # _____ Date of Birth: _____ Gender: ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip: _____

Phone #_____ Cell #_____

INSURANCE INFORMATION

Primary Insurance Company: _____ Policy # _____

POLICY HOLDER: (if different then self) Relationship to Patient: ☐ Self ☐ Spouse ☐ Mother ☐ Father

Name: Last _____ First _____ MI_____

Social Security # _____ Date of Birth: _____ Gender: ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip: _____

Phone #_____ Cell #_____

Secondary Insurance Company: _____ Policy # _____

POLICY HOLDER NAME: _____ **DOB**: _____

Consent for services and/ or disclosure of Protected Health Information: I consent to treatment for myself or above minor child. I am aware that I will be responsible for co-payment, deductible, co-insurance or full payment at the time of service. Any pre-certification requirements that my insurance company requires is my responsibility to make. Furthermore, I allow **DELTA URGENT CARE** to accept assigned payments made by my insurance company on my behalf. I understand that by my lack of payment in full or if my insurance denies payment, I am responsible for payment in full for services rendered. My failure to pay may result in collection proceedings and/or late fees. In addition, I authorize DELTA URGENT CARE to release to my primary care physician or specialty referral, any and all information related to my treatment at this clinic.

_____ _____

Signature of patient or parent/guardian if minor Date