PATIENT INFORMATION

Patient Name_____Birthdate_____Sex_____
Address_____City/State_____Zip_____
Phone_____SS#_____Marital Status_____
Place of Employment_____Phone #_____
Patient Race ☐American Indian/Alaskan ☐ Asian/Pacific Islander☐ Black ☐ Caucasian ☐ Other ☐ Unknown/I do not wish to respond
Patient Ethnicity ☐ Hispanic Origin ☐ Not of Hispanic Origin ☐ Unknown/I do not wish to respond Language_____
Emergency Contact_____ Phone #_____

IF PATIENT IS A CHILD, PLEASE GIVE COMPLETE INFORMATION ON PARENTS OR GUARDIAN

Mother's Name_____SSN#_____Home Ph#_____
Address_____City_____State_____Zip_____
Employer Name_____Work Phone#_____
Father's Name_____SSN#_____Home Ph#_____
Address_____City_____State_____Zip_____
Employer Name_____Work Phone#_____

INSURANCE INFORMATION

Primary Insurance_____
Who Holds Insurance_____Birthdate_____
Relationship to Patient_____SSN#_____
Secondary Insurance_____
Who Holds Insurance_____Birthdate_____
Relationship to Patient_____SSN#_____

PATIENT CONSENT FOR TREATMENT

I hereby authorize treatment by the providers of this practice and/or their assistants. I authorize the release of any information necessary to determine liability payment and to obtain reimbursement on any claim. I request that payment of authorized benefits to be made on my behalf and I assign benefits payable to which I am entitled, including Medicare, private insurance or other healthplans, to this practice. I understand it is my responsibility to pay any deductible and/or copay amount, and that I am financially responsible for all charges whether or not paid by said insurance. I give you and any of your agents, permission to call me on any phone number I have provided you, including all cell phone numbers, for the purpose of collecting my debt. I authorize Mustang Urgent Care to electronically access my eligibility and medication history from my insurance company.

My signature below acknowledges that I have been given the chance to review a copy of the Notice of Privacy Practices.

Signature_____Date_____