MED FAST Urgent Care Centers

PATIENT INFORMATION

Date:_____

Reason for Your Visit: _____

E-Mail Address _____

Cell Phone_____ **Home Phone**_____

Last Name: _____ First Name: _____ M.I. _____

Address:_____APT/UNIT #_____

City:_____ State: _____ Zip Code: _____

Birth Date: _____ Age: _____ Sex: _____ Social Security # _____

Race:_____ Primary Language:_____

Employer:_____ Employer Phone #:_____

Is This A Work Related Problem: **Yes _____** **No _____**

Is Today's Visit Auto Accident Related: Yes _____ No_____

Please list any impairments (visual, hearing or other) _____

Insurance Company: _____ Group ID # _____

Patient's Relationship to Insurance Policy Holder: Self ( ) Spouse ( ) Dependent ( ) Other ( )

Policy Holder Name (If different from patient):_____ Insured Date of Birth: _____

If patient is a minor-who is responsible financial party?_____

Address:_____ City: _____ State: _____ Zip: _____

Emergency Contact: _____Phone:( ) _____ Relationship _____

Family Physician:_____ Phone:( )_____

Your Pharmacy Name: _____ Location:_____

How did you hear about us?

TV/COMMERCIAL_____

Doctor (Name)_____ Newspaper (which one)_____ Building Sign _____

Internet_____ Friend/Relative_____ Flyer/Mail_____ Other _____

_____ _____

Patient Signature / Parent or Legal Guardian DATE:

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