MED FAST Urgent Care Centers

PATIENT INFORMATION

Date:_____

Reason for Visit: _____

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

Is Today's Visit Auto Accident Related: **Yes** _____ **No**_____

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

Address:_____

City:_____ State: _____ Zip Code: _____

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

Race:_____ Primary Language:_____

Home Phone_____ Cell Phone_____ Work Phone_____

E-Mail Address _____

Employer:_____ Address:_____

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

Insurance Company: _____ Group ID # _____

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

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

If Insurance Subscriber's address is different than above, please fill in address:

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

Emergency Contact: _____**Phone:( )** _____ **Relationship** _____

Family Physician:_____ Phone:( )_____

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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