MED FAST Urgent Care Centers

PATIENT INFORMATION

Date: _____

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

Address: _____ APT/UNIT#_____

City: _____ State: _____ Zip Code _____

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

Phone: _____ Race: _____ Primary Language: _____

E-Mail Address: _____

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

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

Is This a Work Related Problem: Yes _____ No _____

(If Yes) Employer: _____Employer Phone #: _____

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 the patient is a minor, who is the responsible financial party? _____

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

Emergency Contact: _____ Phone:_____ Relationship: _____

Family Physician: _____ Phone:_____

Your Pharmacy Name: _____ Location: _____

_____ _____

Patient Signature / Parent or Legal Guardian **DATE**