SUGARLOAF URGENT CARE

NEW PATIENT FORM

Today's date: / / PCP:	

PATIENT INFORMATION

Patient's Last name:	Marital status (circle one)
First:	Single / Married / Divorced /
Middle:	Separated / Widowed
Is this your legal name? ☐ Yes ☐No **Email :**	
If not, what is your legal name?	
Birth date: / / Age: Sex: ☐ M ☐F	

Street address:	Social Security #	Home/Cell #
	- -	( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.:
		( )

How did you hear about us? (*please check one box*):	❑ Dr.	❑ Insurance Plan	❑ Hospital	❑ Family
☐ Yellow Pages	❑ Internet	❑ Other		

Pharmacy Name:	Pharmacy phone #:

INSURANCE INFORMATION

(Please give your Picture ID and insurance card to the receptionist)

Person responsible for bill:	Responsible person's D O B: / /
Address (if different):	
Home phone no: ( )	Cell phone no: ( )

Is this person a patient here?	❑ Yes	Name of insurance co:
	❑ No	

Occupation:	Employer Name:	Employer phone no.:
	Employer Address:	( )

Is this patient covered by insurance? ☐ Yes ☐No			
Primary Insurance Co:	Group no:	Policy no:	Co-pay: $
Subscriber's Name:	Subscriber D O B: / /		
Patient's relationship to subscriber: ☐ Spouse ❑ Self ☐ Child			

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Home phone no:	Work phone no:
	( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize SUGARLOAF URGENT CARE or insurance company to release any information required to process my claims.

Patient/Guardian Signature: **Date: / /**