Urgent Care Form

Patient Information			
Name:		**Date of Birth:**	
Address:			
Gender:	Male Female Other:		
Email:		**Contact #:**	
Emergency Contact Name:			
Emergency Contact #:		**Relationship:**	
Reason for Visit:			

Known Allergies:	**Current Medications:**
Chronic Conditions or Ongoing Treatment	**Previous Surgeries / Hospitalizations**

Responsible Party / Guardian Information (if under 18 or dependent)			
Name of Parent / Guardian:			
Relationship to Patient:			
Address:			
Email:		**Contact #:**	

Patient Insurance Information	
Insurance Provider:	**Policy Number:**
Policyholder's Name:	**Group Number:**

Consent for Treatment
• I consent to receive medical treatment and understand that I am responsible for any charges not covered by insurance. • I authorize the release of medical information necessary for insurance claims and understand that my information will be kept confidential.

Patient Signature

Responsible Party's Signature