Patient First Name:____________________________**MI:**________**Last Name:**______________________________

DOB:________/___________/_________ Social Security Number:____________-_____________-____________

Reason for today's visit:____

Gender(circle) Male Female

Marital Status (circle) Single Married Divorced/Separated Widowed

Race (circle) Decline African American Hispanic Asian White Other:_________________________

Language Preference(circle) Decline English Other:____

Address: ____ Apt/Suite:_________________

City: ____State:____________ Zip:____________________________

Home #:(________)________-___________Cell #: (________)___________ County:______________________________

email____**@**____________________

Emergency Contact: _____________________________________Relationship__________________________________

Phone#:(________)________-___________

Reason for today's visit(circle) Office Visit Nurse Visit Work related Injury Motor Vehicle Accident

Pharmacy of Choice_____________________________________Location_____________________________________

Primary Care Doctor:________________________________When was your last physical:_______/_______/_______

Name of Primary Insurance Company____

Who is responsible for insurance(Circle) Self Mom Dad Spouse Other:________________________

Name of Responsible Party:_______________________________________ Phone#:(________)________-____________

DOB:________/___________/_________ Social Security Number:____________-_____________-____________

Responsible Party Address: ____Apt/Suite: _________

City: ____State: ________ Zip: ____________________

Name of Secondary Insurance Company____

Who is responsible for insurance(Circle) Self Mom Dad Spouse Other:________________________

Name of Responsible Party:_______________________________________ Phone#:(________)________-____________

DOB:________/___________/_________ Social Security Number:____________-_____________-____________

Responsible Party Address: ____Apt/Suite: _________

City: ____State: ________ Zip: ____________________

If you have a tertiary insurance please notify the front desk

Patient Name:____ **DOB:**____________________

Assignment of Benefit Agreement

I hereby authorize my insurance company, including Medicare if I am a Medicare beneficiary, to make payments to Port City Urgent Care and Family Practice for medical or surgical services or items rendered to me or my dependent by Port City Urgent Care and Family Practice. Should my insurance carrier deny Port City Urgent Care and Family Practice payment, I understand that I am financially responsible for the charges. I am aware that any unpaid balances will be sent to collections and will incur an additional 30% collections fee. I authorize Port City Urgent Care and Family Practice to release any and all of my records to my insurer, or any other third party payer, legally responsible for the payment of medical expenses. I certify that the information provided or to be provided by me is correct and complete to the best of my knowledge. It is my responsibility to update any and all personal, insurance, and health information.

Authorization for Medical Treatment

I give my consent to Port City Urgent Care and Family Practice, its physicians and healthcare professionals, nurses, and other personnel to provide treatment for me or my dependent.

Release of Information

I permit Port City Urgent Care and Family Practice, its physicians, physician assistants, healthcare professionals, nurses, and other personnel to discuss health information, in person or by telephone, with the following family members or friends involved in my medical care.

Name:______________________________ Phone#:(_______)_______-_________Relationship___________

Name:______________________________ Phone#:(_______)_______-_________Relationship___________

Receipt of Notice of Privacy Practices Written Acknowledgment

A copy (located at check-in window by print out and/or poster) of the Notice of Privacy Practices from Port City Urgent Care and Family Practice has been made available to me.

Signature of Patient (or Responsible Party):______________________________**Date:**_________________

Name of Responsible Party if Different From Patient: ____

Witness signature (Office Staff)_______________________________________**Date:**___________________