NEIGHBORHOOD primary care

| Patient's First Name | Middle Initial | Last Name |
|---|---|---|
| | | |

| DOB | Age | Sex | Race |
|---|---|---|---|
| | | Female Male | White African American Hispanic Other |

| Address | City | State | Zip |
|---|---|---|---|
| | | | |

| Social Security Number | Home Phone Number | Mobile Phone Number |
|---|---|---|
| | | |

| Email Address | Pharmacy Choice | Pharmacy Phone Number |
|---|---|---|
| | | |

| How did you hear about us? | Have you been treated here before? | Do you have a Durable Power of Attorney for HealthCare? Yes No<br>Do you have a living will? Yes No (If yes, Please Provide us with a copy) |
|---|---|---|
| | Yes No | |

| Person/Guarantor Responsible for Payment of Services (If Different from Patient) | Relationship To Patient |
|---|---|
| | |

| Address: | City | State | Zip | Phone |
|---|---|---|---|---|
| | | | | |

| Emergency Contact (Not within the same household) | Emergency Phone Number | Relationship To Patient |
|---|---|---|
| | | |

| Primary Insurance | | Secondary Insurance | |
|---|---|---|---|
| **Insurance Name** | **Effective Date** | **Insurance Name** | **Effective Date** |
| | | | |
| **Subscriber ID Number** | **Group Number** | **Subscriber ID Number** | **Group Number** |
| | | | |
| **Subscriber Birthdate** | | **Subscriber Birthdate** | |
| | | | |
| **Subscriber SS #** | **Relationship to Patient** | **Subscriber SS #** | **Relationship to Patient** |
| | | | |

The Patient is responsible for payment in full of all services rendered by the provider or employees of Neighborhood Urgent Care, Payment in full is expected at the time of service unless arrangements are made in advance.

**AUTHORIZATION, ASSIGNMENT, AND RESPONSIBILITY OF ACCOUNT:** I hereby authorize Neighborhood Urgent Care, to release to the above insurance companies &/or carriers any medical or other information needed for claim reimbursement. I hereby assign transfer, and set over to Neighborhood Urgent Care all of my rights, title, and interest to medical reimbursement benefits under my insurance policy with the above documented insurance companies. I hereby acknowledge and accept responsibility for payment in full of all services rendered to me by Neighborhood Urgent Care.

_____ _____

SIGNATURE OF PARENT/GUARDIAN DATE