

Welcome to Urgent Care-Cypress

Name _____ Marital Status: Married Single Widow Divorced
Address _____ Are you a full-time student? Yes No
City _____ State _____ Zip _____ Employer _____
Home Phone () _____ Address _____
Cell Phone () _____ City _____ State _____ Zip _____
Social Security # _____ Work Phone () _____
Birthday _____ Age _____ Gender: M / F Do you work: Full / Part-Time?
Emergency Contact _____ Phone # _____ Relationship _____
Primary Care Physician _____ Phone # _____
If none, would you like to be referred to one? Yes No
Accident Information: Work Comp Auto Other Date of Injury/Accident: _____

Primary Insurance *(must complete if you are not the named policy holder)*

Insurance Name _____ Phone # _____
Policy Holder's Name _____ Birthday _____
Relationship _____ Policy Holder Social Security # _____
Employer *(include address)* _____

Secondary Insurance/Work Comp or Auto *(if applicable)*

Insurance Name _____ Phone # _____
Policy Holder's Name _____ Birthday _____
Relationship _____ Policy Holder Social Security # _____
Employer *(include address)* _____
Policy or Claim # *(if applicable)* _____ Adjuster _____

Insurance Authorization and Assignment of Benefits and Medical Record Release:

I hereby authorize Urgent Care-Cypress to furnish information to insurance carriers concerning my illness and treatments. I hereby authorize payment directly to the physician for medical and/or surgical benefits, if any otherwise payable to me or my dependants for physician services as described by the statement of services rendered. I understand that any balance remaining on my account after my insurance carrier has made payment is my responsibility and must be paid in full within 30 days, unless satisfactory financial arrangements are made.

I also hereby authorize Urgent Care-Cypress to release or obtain my medical information to or from the referring physician, family physician, and/or transferring physician. I agree that a photocopy of this authorization may be considered a valid authorization. I understand that I can revoke this authorization at any time by notifying Urgent Care-Cypress in writing.

Signature *(required)* _____ Date _____