Total Medical and Urgent Care

Information del Patiente

Nombre: _____ Inicial _____ Apellido: _____

S.S.#_____ Nacimiento: _____/_____/_____

Direccion: _____ Ciudad: _____ Estado : _____ codigo: _____

Home Phone: (____) _____-_____ Alternative phone: (_____) _____-_____ Sex: M / F Marital Status: S M D W

Trabajo: Full Time / Part Time / Retired
Employer: _____ Work Phone #: (_____) _____-_____
Address: _____ City_____ ST: ____ Zip: _____

Estudiante: Full Time / Part Time
Escuela _____

Persona asegurada (Primario de Seguro)

Nombre: _____ Initial.: _____ Apellido: _____

S.S.#_____ Fecha de Nacimiento: _____/_____/_____

Direccion: _____ City: _____ ST: _____ Zip: _____

Home Phone: (____) _____-_____ Alternative phone: (_____) _____-_____ Sex: M / F Marital Status: S M D W

Trabajo: Full Time / Part Time / Retired
Employer: _____ Work Phone #: (_____) _____-_____
Address: _____ City_____ ST: ____ Zip: _____

Payment & Insurance Information (we will need a copy of your insurance card) (Informacion de su Seguro Medico)

Primary Insurance: _____ Phone Number: (_____) _____-_____
ID#: _____ Group#: _____

Other Insurance: _____ Phone Number: (_____) _____-_____
ID#: _____ Group#: _____

Contactos en caso de emergencia:
In case of any emergency or I'm unable to be contacted by the doctor I hereby allow for the follow people to receive information regarding my health. Anyone not on the list will not be notified. Initials: _____

Name:	*Phone #:*	*Relationship:*
1. _____	(_____) _____-_____	_____
2. _____	(_____) _____-_____	_____
3. _____	(_____) _____-_____	_____

AUTHORIZATIONS & ACKNOWLEGMENTS

I hereby authorize Total Medical and Urgent Care to furnish information to my insurance carrier(s) concerning my illnesses and treatments. Initials: _____
I hereby assign to the doctor all payments for medical services rendered to me or to my dependents. I understand that I am responsible for any amount not covered by insurance. Initials: _____

Signature: _____ Date of Service: _____
(Patient/ Parent/ Guardian)