URGENT CARE CLINIC Date:__________

Patient Name: ________________________ DOB: ____________ Sex: M _______ F ________

Address: ____________________________ City: _____________ State:_______ Zip: ________

Telephone: (Home) (___)__________ (Cell) (___)______________ (Work) (___)_____________

Marital Status: M ___ S ____ D ___ W ___ SS #: ____

Employed By/School: _____________________________ Occupation/Student: _____________

Address: ____________________________ City: _____________ State:_______ Zip: ________

MEDICAL INSURANCE: Yes: ______ No: ________ Co-Pay Amount: ________________

Insurance Company (Primary): ____

Policy #: ________________ Group #: _______________ Telephone: ____________________

Member Name: ________________ DOB: ____________ SS #: _________________________

Relationship to Patient: ____

Insurance Company (Secondary): ____

Policy #: ________________ Group #: _______________ Telephone: ____________________

Member Name: ________________ DOB: ____________ SS #: _________________________

Relationship to Patient: ____

Primary Care Physician (First and Last Name):____

Address: ____ Telephone: ____________________

Emergency Contact: ______________________________ Telephone: ____________________

Name Relationship

ASSIGNMENT OF BENEFITS: I request that assignment of authorized Medicare / Other Insurance Company benefits be paid either to me or on my TO behalf McAlester Community Care, Urgent Care Clinic for any services furnished me by that party who accepts assignment. Regulations pertaining to Medicare assignment of Administration and Health Care Financing Administration any information needed for this or any related Medicare/Other Insurance Company claim. The assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I also understand that regardless of my insurance status, I am ultimately responsible for the balance on my account. If I am using out of network benefits, I am responsible for any deductible and / or co-insurance.

SIGN: ___________________________________ DATE: ____________________