PATIENT INFORMATION

URGENT CARE AND OCC MED

4328 ARMOUR ROAD COLUMBUS, GA 31904

Ucom staff only
Time in:_____
Copay:$__ _____via _____

Name_____Date of birth_____Sex M F Marital status: M S W Sep D

Street Address_____City_____State_____ Zip_____

Mailing Address_____City_____ State_____ Zip_____

Telephone: (Home)_____ (Cell)_____ (Work)_____

Reason for your visit today:_____ Date of onset/accident_____

Social security #_____ Primary Care Physician_____Preferred Pharmacy_____

Emergency contact_____ phone_____secondary phone_____

PATIENT EMPLOYER INFORMATION

Employer name_____ Telephone #_____

Employer street address_____ City/State_____ Zip_____

Patients occupation_____ Patient social security no._____

INSURED PERSON (IF NOT PATIENT)

Name_____ Telephone #_____

Street Address_____ City/State_____Zip_____

Relationship to patient_____ Insured's date of birth_____

Insured's Employer/Address:_____

INSURANCE

Medicare # (if applicable)_____ Medicaid # (if applicable)_____

Primary Insurance Company Name_____

Policy ID #_____ Group #_____ Telephone #_____

Secondary Insurance Company Name_____

Policy ID #_____ Group #_____ Telephone #_____

INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Date_____ Signature_____

I hereby authorize Urgent Care and Occ Med physicians/staff to apply for benefits on my behalf for covered services rendered by him/her, or by his/her order. I request that payment from my insurance company be made directly to Urgent Care and Occ Med (or to the party who accepts assignment).
I certify that the information I have reported with regard to my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing. I have read and understand the HIPAA Rules and Regulations and acknowledge a copy will be provided to me if requested.

***********LIST ALL CURRENT MEDICATIONS ON BACK************

Date_____ Signature_____

(Patient, parent, or guardian)