

Edinger Urgent Care Patient Information Sheet

Company Name: _____

Reason for Visit: _____

Injury Information (If applicable):

Date of Injury/Illness: _____ Time of Injury/Illness: _____

Have you been treated elsewhere for this injury listed above? Yes No

If yes, where or by whom? _____

Patient Information:

Social Security: _____ - _____ - _____ Name to be called: _____

First Name: _____ Last Name: _____

Street Address: _____

City: State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

E-mail Address: _____

Date of Birth: _____ Gender: _____

Race: _____ Marital Status: _____

DOT Information:

Driver's License Number: _____ State: _____

CDL/CLP: Class: _____

Emergency Contact:

Name: _____ Phone: _____

Insurance Information (if applicable):

Private Insurance

Name of Insurance: _____

Body Part Injured : _____

How did injury happen? _____
