Fast Access HEALTH CARE

Urgent. Primary. Care

DEMOGRAPHIC INFORMATION

LEGAL NAME: _____
First *Middle/Maiden* *Last*

DATE OF BIRTH: _____ **SOCIAL SECURITY: NUMBER:** _____

ADDRESS: _____
Street *City, State Zip*

PHONE NUMBERS: _____
Home *Cell* *Work*

EMAIL ADDRESS: _____

OCCUPATION: _____ **EMPLOYER:** _____

PHYSICAL GENDER: **Male** or **Female** **MARITAL STATUS:** S, M, Div, Sep, Wid

PAYMENT/INSURANCE INFORMATION

RESPONSIBLE PARTY: _____
First *Middle/Maiden* *Last*

DATE OF BIRTH: **SOCIAL SECURITY: NUMBER:**

ADDRESS: _____
Street *City, State Zip*

PHONE NUMBERS: _____
Home *Cell* *Work*

OCCUPATION: _____ **EMPLOYER:** _____

PRIMARY INSURANCE

INSURANCE SUBSCRIBER: _____

RELATIONSHIP TO PATIENT: **SELF** **SPOUSE** **PARENT** **OTHER:** _____

INSURANCE CO: _____ **COPAYMENT:** _____

SUBSCRIBER SSN: _____ **SUBSCRIBER DOB:** _____

GROUP #: _____ **POLICY/ID#** _____

SECONDARY INSURANCE

INSURANCE SUBSCRIBER: _____

RELATIONSHIP TO PATIENT: **SELF** **SPOUSE** **PARENT** **OTHER:** _____

INSURANCE CO: _____ **COPAYMENT:** _____

SUBSCRIBER SSN: _____ **SUBSCRIBER DOB:** _____

GROUP #: **POLICY/ID#**

*Do you have a tertiary insurance policy? **YES** or **NO** If so, please include that information on the reverse of this form.

PHARMACY INFORMATION

PHARMACY NAME: **PHONE NUMBER:**

PHARMACY ADDRESS:

EMERGENCY CONTACT INFORMATION

NAME: _____

PHONE NUMBER: _____ **RELATIONSHIP** _____

Other persons with whom we may share your personal health information:

May we leave personal health information in voicemail? **YES** or **NO**

The above information is true to the best of my knowledge. I consent to medical treatment by Fast Access Healthcare, PLLC (Provider) in office, home, ALF, or via televisit with or without recording. I understand I have a right to be informed if the provider refers me to a facility in which provider has ownership or investment interest. I hereby authorize Provider to release any information necessary to process insurance claims, prescriptions, referrals, authorizations, collections accounts for unpaid bills, etc. I authorize Provider to request, provide, and use my personal health information & prescription medication history from/to other healthcare Providers and/or third-party pharmacy organizations. I authorize Provider to enroll me in ePrescribe/escripts/Surescripts and/or other third-party pharmacy vendors. I authorize my insurance benefits to be paid directly to Provider. I understand that I am financially responsible for any balance and all associated collection fees & authorize the release of information to a collections agent should my bill go unpaid. I agree to pay a no-show fee of $35 for any scheduled visit that I miss without prior notification. I have had an opportunity to ask questions, and I understand these statements.

SIGNATURE: **DATE:**