ARMSTRONG URGENT CARE

Patient's Demographics

First Name Last Name Middle

Sex: (Circle One) M F DOB SSN

Address

City State Zip Code

Home Number Mobile Number

Email Address

Contact Preference:(Circle One) Home# Mobile# Mail Email Patient Portal

Status: Single Married Divorced Widowed Other

Emergency Contact Information

Emergency Contact Name Relationship

Home Number Mobile Number

Insurance Information

Primary Insurance Name ID Number

Policy Holder's Name Policy Holder's DOB

Secondary Insurance Name ID Number

Policy Holder's Name Policy Holder's DOB

Responsible Party/Guarantor (Patients under 18)

First Name Last Name Relationship

Address

City State Zip Code

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Armstrong Urgent Care. I acknowledge that I am financially responsible for payment whether or not covered by insurance. Further, I understand that my insurance company may not cover 100% of my bills for services provided, and that I will be responsible for the payment of any remaining balance due. Furthermore, I understand that it is my responsibility to have obtained any and all necessary referrals and authorizations required prior to treatment by Armstrong Urgent Care, Inc. If my insurance company requires a referral and I do not have one, then I understand that I will be responsible for the entire bill for rendered services, or have the referral delivered to the office before I leave.

I understand that it is my responsibility to confirm that the provider that I see at Armstrong Urgent Care is a participating provider under my insurance policy.

Signature Date