Sample Urgent Care Patient Intake Form

Please present your insurance card at time of check-in.
Settlement of patient financial responsibility is expected at time of service.

TYPE OF VISIT: ☐ **Insurance (present card at check-in)** ☐ **Self-pay (payment due at time of service)**

☐ **On-the-job injury** ☐ **Other:** _____

Patient Name:		
Last:	**First:**	**Middle:**
Date of Birth:	**Social Security Number:**	**Sex:** ☐ **M** ☐ **F**
Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Separated**	**Spouse Name:**	
Street Address:		**City, State, ZIP**
Home Phone: ☐ **Preferred**	**Cell Phone:** ☐ **Preferred**	**Work Phone:** ☐ **Preferred**
May we leave a message regarding your care (x-ray, lab results) on your preferred phone? ☐ **Y** ☐ **N**	**Employer:**	**Occupation:**

Please state your reason for today's visit:
Are you experiencing any of the following? Please stop and notify attendant immediately.
☐ **SEVERE chest pains** ☐ **SEVERE shortness of breath** ☐ **Uncontrolled bleeding** ☐ **Allergic reaction** ☐ **Any other life-threatening condition**
Is this an on-the-job or other work-related injury? ☐ **Y** ☐ **N** ***If so, please complete the following:***

Employer Name:	**Supervisor:**
Street Address:	**City, State, ZIP**
Description of Injury or Symptoms:	**Date of Injury:**

How did you hear about us?
☐ **Drive-by/signage** ☐ **Insurance company directory**

Sample provided by UCAOA member.

☐ **Physician referral (Name:_____)**
☐ **Friend/relative/co-worker**
☐ **Advertising (Specify: _____)**

Parent or Guarantor's Name: *Complete with name of insured if the patient is not responsible for his or her charges today.*		
Last:	**First:**	**Middle:**
Date of Birth:	**Social Security Number:**	**Sex:** ☐ **M** ☐ **F**
Street Address:		**City, State, ZIP**
Home Phone:	**Work Phone:**	**Employer:**

Insurance Information: *Please notify staff if secondary insurance should be billed.*		
Carrier:	**Subscriber ID:**	**Group Number:**
Policy Holder Name:	**Card Number:**	**Card Date:**
Claim Address:		**Phone:**

Primary Care Physician: *Should we fax or mail a copy of your chart?* ☐ **Y** ☐ **N**		
Name:	**Phone:**	**Fax:**

Emergency Contact (Not living at same residence):		
Name:	**Phone:**	**Relation:**

Medical History:
List all medications and doses (including vitamins):
List all known allergies and specific reactions:

Sample provided by UCAOA member.

List any additional conditions you would like to notify or discuss with the physician:

Authorization and Release

Authorization For Treatment: I voluntarily consent to the administration and cost of medical and surgical procedures, x-ray, and medication for myself and my dependents.

Assignment of Insurance Benefits: I authorize payment directly to this urgent care center for all benefits otherwise payable to me.

Guarantee of Payment: I understand that I am financially responsible and agree to pay all of the charges that are not paid or billed to insurance or any other third party payer. I understand that I must pay in full today for all services rendered unless my insurance is accepted. I also understand that if my insurance is accepted, I must pay all applicable insurance copays, coinsurances, and deductibles today. If you are unable to verify my insurance at time of service, I will pay in full for all services.

Release of Records: I authorize this urgent care center to release (verbal or in writing) confidential medical information to any person or entity including my insurance carrier, employer if treatment is related to employment purposes, or other health care operations which may be liable to me or my practitioner(s) for charges for this treatment and for quality management, utilization review, transfer, and follow-up purposes.

Receipt of Privacy Practices: I acknowledge that I have received and read the Notice of Privacy Practices of this urgent care center.

I understand that a copy of this agreement may be used with the same effectiveness as the original.

PATIENT SIGNATURE _____ DATE _____/_____/_____

RESPONSIBLE PARTY _____ DATE _____/_____/_____

REVIEWED BY _____ DATE _____/_____/_____

Sample provided by UCAOA member.