



Premier Urgent Care



Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____

Age: _____ DOB: _____ Sex: _____ SS#: _____

Marital Status: _____ Person Responsible for account: _____

Address: _____

Permanent (If P.O. Box please provide street address also)

City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ EXT _____ Cell: _____

Temporary Address: _____

City: _____ State: _____ Zip: _____ Temporary Phone: _____

Emergency Contact _____ Phone# _____ Relationship _____

Family Doctor/Internist: _____ Phone# _____

Employer: _____ Phone: _____ EXT _____

Employer's Address: _____ Years with Employer: _____

Spouse's Name: _____ Date of Birth: _____ Spouse's SS#: _____

Spouse's Employer: _____ Employer Phone#: _____

If proper insurance information is not provided on the date of service, our office is not responsible for filing back charges. Please be advised that it is your responsibility to be aware of the benefits that your medical plan provides.

PRIMARY INSURANCE COMPANY

SECONDARY INSURANCE COMPANY

Company: _____

Company: _____

Policy#: _____

Policy#: _____

Group#: _____

Group#: _____

Policy Holder: _____

Policy Holder: _____

Policy Holder DOB: _____

Policy Holder DOB: _____

Phone#: _____

Phone#: _____

****Please indicate the lab your insurance co. uses: ___Quest ___Lab One ___Labcorp ___Wuesthoff ___Health First I understand that if my choice for *LAB DIRECTIVE is incorrect, I am financially responsible for the bill that the lab sends me. If no Lab chosen we will send to Wuesthoff Laboratory automatically.**

I, _____ hereby assign all medical benefits, to include major medical benefits to which I am entitled including Medicare and other government sponsored programs, private insurance, and any other health plans to **D. Badolato P.A./Premier Urgent Care of Brevard, LLC**. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize release to my insurance carrier, employer, and referring physician any information needed including diagnosis and records of any treatment or examination rendered to me to process this claim. Lifetime signature authorization. This authorization and assignment are to be continuing, remaining in force until revoked in writing by the undersigned for services beginning:

Patient/Guardian Signature: _____ Date: _____