## CLEARCHOICEMD URGENT CARE

Date: ______________ CCMD Staff Member: ____________

Last Name:____________________________________First Name: ______________________________________

Date of Birth:_______________________SS#:_________________________Marital Status: ________________

Mailing Address:_____________________________________________________________Sex: M / F

City:_______________________________________State: ___________ Zip Code: _______________________

Home Phone:____________________Cell Phone:____________________Work Phone: ____________________

Email: ___________________________________________________________________________________

Emergency Contact:___________________________ Phone:___________________Relationship:___________

Guarantor (person responsible for bill, if applicable):_______________________________DOB:____________

Guarantor Address (if different from patient):________________________________Relationship:____________

Insurance Policy Holder (if other than patient):______________________________________________________

Insurance Policy Holder Date of Birth: ____________________________________________________________

Primary Care Provider Name: ___________________________________________________________________

Pharmacy and Location: _______________________________________________________________________

Reason for Visit: _____________________________________________________________________________

How did you hear about us:_____________________________________________________(Please be specific)

**Please answer the following three questions:**

1. **Do you want your records sent to your Primary Care Provider? Yes or No**
2. **I have read and understand the Consent for Treatment, Controlled Medication, Assignment of Benefits, Confidentiality, Complaint Procedure, Release of Information, Bill of Rights and Privacy Practice Policies.**
   **Would you like a copy of these policies? Yes or No**
3. **Follow-up Communication: We may contact you after your visit in order to request feedback on your experience. May we contact you via phone call, SMS text message, e-mail or mobile application? Yes or No**

Patient/Guardian Signature:____________________________________________________Date:_____________

Patient/Guardian Printed Name: _________________________________________________________________