DAVIS URGENT CARE

**Reason for Visit:**_____

**Patient Information**

Last Name:_____First Name:_____

Social Security Number:_____Date of Birth:_____Sex: Male/Female

Address:_____City:_____State:_____

Zip Code:_____Phone Number:_____Cell Number:_____

E-mail Address:_____

Employer:_____Phone Number:_____

Address:_____

**Guarantor for Minor: Authorization to treat minor**

Last Name:_____First Name:_____

Social Security Number:_____Date of Birth:_____Sex: Male/Female

Address:_____City:_____State:_____

Zip Code:_____Phone Number:_____Relationship:_____

***Signature of Parent or Legal Guardian:***_____***Date:***_____

**Insurance Information**

Name of Primary Insurance:_____Policy Number:_____

Name of Primary Insured:_____Date of Birth:_____

Address:_____City:_____State:_____

Zip Code:_____Phone Number:_____Relationship:_____

Name of Secondary Insurance:_____Policy Number:_____

Name of Primary Insured:_____Date of Birth:_____

Address:_____City:_____State:_____

Zip Code:_____Phone Number:_____Relationship:_____

**Primary Care Physician**

Name of Doctor:_____Phone Number:_____

Location:_____Fax Number:_____

**Please complete the back of this form**

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**Emergency Contact**

Last Name:_____First Name:_____

Phone Number:_____Cell Number:_____Relationship:_____

## Consent for Treatment

I consent to the performance of all routine medical care and treatment (e.g. tests, therapy, medical treatment or procedures, etc.) which may be performed as deemed necessary by and under the general and special instructions of the physician and/or authorized health care providers of Davis Urgent Care.

## Release of Information

I agree that, to the extent necessary to determine liability for payment and to obtain reimbursement, or as otherwise permitted or required by law, Davis Urgent Care may disclose any portion of my/the patient's medical records including but not limited to, information about patient's diagnosis and/or treatment relating to medical, mental health, developmental disability, and/or substance abuse treatment to any government agency or corporation including, but not limited to, insurance companies, employers, or health service plans to ensure coordination of my/the patient's ongoing care and treatment. I also release any medical information to the patient's primary care physician or any consulting physicians or health care providers participating in my/the patient's care.

## Privacy Notice: HIPAA

By signing this section, you acknowledge understanding of the above Notice of Privacy Practices of Davis Urgent Care provides and information about how we may use or disclose your protected health information. We encourage you read it fully.

***Print name of Patient:***_____

***Print name of Person signing below:***_____***Relationship:***_____

***Signature of Patient or Legal Guardian:***_____***Date:***_____

## Authorization

The undersigned certifies that he/she has read the information noted above and has been given the opportunity to have questions answered fully regarding the above information and to his/her satisfaction, and has the option to receive a copy of this agreement upon request. The undersigned further certifies that he/she is 1) the patient 2) the patient's legal representative or 3) is duly authorized by the patient as the patient's general agent to execute the above and accepts its terms.

***Print name of Person signing below:***_____***Relationship:***_____

***Signature of Patient or Legal Guardian:***_____***Date:***_____

**How did you hear about Davis Urgent Care?**

[ ] Monument Sign [ ] Google/Yahoo Search [ ] Yellow pages [ ] Local News

[ ] Friend/Relative [ ] Pocket Newspaper [ ] Doctor/Insurance [ ] Other