AfterOurs Urgent Care Patient Information

REASON FOR BEING SEEN: _____

PATIENT NAME: _____

ADDRESS: _____ **APT/Ste:** _____

CITY: _____ **STATE:** _____ **ZIP:** _____

HOME #: _____ **CELL #:** _____ **DOB:** _____

SS #: _____ **SEX:** ☐ **F** ☐ **M** **MARITAL STATUS:** _____ **HT:** _____ **WT:** _____

DRUG ALLERGIES: _____

MEDICATIONS: _____

DOCTOR/PCP: _____ **PHARMACY:** _____

EMAIL: _____

☐ **Check here if you would like more information on HealthTracker, a service to view and pay your statements online.**

EMERGENCY CONTACT: _____ PHONE: _____ RELATION: _____

PRIMARY INSURANCE NAME: _____ (PLEASE PROVIDE CARD)

POLICY HOLDER NAME: _____ DOB: _____ SS #: _____

POLICY #: _____ GROUP #: _____ RELATION TO PATIENT: _____

SECONDARY INSURANCE NAME: _____ (PLEASE PROVIDE CARD)

POLICY HOLDER NAME: _____ DOB: _____ SS #: _____

POLICY #: _____ GROUP #: _____ RELATION TO PATIENT: _____

HOW DID YOU HEAR ABOUT AFTEROURS URGENT CARE? (Please circle all that apply)

Postcard	Family Member	Building Sign	*Directory:*	*Online Search:*	Other: _____
Letter	Magnet	Friend	Yellowbook	Google Yahoo	
Newspaper	Insurance	Magazine	Yellowpages	Ask.com MSN	Doctor:
Radio	Billboard	Ask A Nurse	Superpages	FindUrgentCareNow.com	_____

REGISTERED HEALTHTRACKER USERS ONLY:

☐ Check here to confirm that you will check your balance online regularly. NO paper statements will be mailed once you check this box. Thank you for considering the environment.

CONSENT TO TREAT: I voluntary consent to medical treatment and procedures that may be performed on me during this visit. This includes, but is not limited to, medical, therapy, or surgical care, x-rays, tests, medications, laboratory test, or other services, which may be ordered by the physician participating in my care.

ASSIGNMENT OF INSURANCE BENEFITS, PAYMENTS, AND RELEASE OF MEDICAL RECORDS: I hereby authorize payment of medical benefits to AfterOurs™ Inc. I further authorize the release of any medical/surgical information necessary for determining the extent of third-party coverage and for processing an insurance claim on my behalf. I permit a copy of this authorization to be valid as the original. I understand that I am ultimately responsible for and agree to pay all charges and expenses of the clinic for services, supplies, and food furnished to me which are not paid through benefits for prepaid healthcare, insurance plans, or medical assistance. If for any reason my account is forwarded to a collection agency or attorney for non-payment, I agree to pay all collection cost, court cost, attorney's fees and other reasonable cost incurred if I am found liable for amounts due to AfterOurs™ Inc.

Patient, Responsible party, or Guarantor Signature:

X_____ Date: _____

Print Name: _____ Social Security #: _____

I, the undersigned, have been offered a copy and understand the Privacy Practice of the AfterOurs, Inc.

X_____ Date: _____

Responsible Party

****Responsible party please provide current address if different from patient!****