KEY WEST URGENT CARE, INC.

1501 GOVERNMENT ROAD, KEY WEST, FL 33040

PATIENT INFORMATION AND MEDICAL HISTORY **DATE _____**

PATIENT NAME (LAST) _____(FIRST) _____(MI) _____

MALE / FEMALE MARITAL STATUS _____ DATE OF BIRTH _____

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE WHERE YOU CAN BE REACHED #1 _____

#2 _____

SOCIAL SECURITY # _____

PHARMACY YOU WISH TO HAVE PRESCRIPTIONS CALLED TO WHEN NECESSARY

_____

EMPLOYER _____EMPLOYER PHONE _____

INSURANCE _____

NAME OF INSURED _____ SOCIAL SECURITY # _____

ALTERNATE CONTACT NAME _____

* ALLOWED TO OBTAIN PERSONAL INFORMATION ABOUT PATIENT BY TELEPHONE

PHONE _____ RELATIONSHIP _____

I consent to diagnosis, treatment and testing provided by Key West Urgent Care, Inc.

I certify that if I (or my dependent) have insurance coverage, I will assign directly to Key West Urgent Care all insurance benefits for claims submitted by them. I authorize release of all information necessary to secure payment of insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize use of this signature on all insurance submissions.

I have been provided the opportunity to review the privacy practices policy of Key West Urgent Care, Inc. Written policy available across from the front desk.

I understand payment is due at the time of service.

SIGNATURE OF PATIENT OR GUARDIAN _____

PLEASE SEE OTHER SIDE