Patient Information

DOCTOR OF RECORD
Samuel Hague MD

AMC Urgent Care Plus

PATIENT NAME (First Name, Middle Initial, Last Name)	PATIENT ID (Office Use Only) 47775	FIRST PHONE (HOME)	SECOND PHONE (WORK)	THIRD PHONE (MOBILE)
ADDRESS	DATE OF BIRTH	SOCIAL SECURITY NUMBER	SEX (M or F) [ ]M [ ]F	MARITAL STATUS [ ]Married [ ]Single [ ]Other
CITY, STATE, ZIP	AGE	EMERGENCY CONTACT PERSON	RELATIONSHIP TO PATIENT	CONTACT PHONE
EMPLOYER		OCCUPATION	PATIENT E-MAIL ADDRESS	
REFERRING DOCTOR NAME & ADDRESS				
PRIMARY CARE DOCTOR NAME & ADDRESS				

Responsible Party

RESPONSIBLE PARTY NAME (First Name, Middle Initial, Last Name)			
ADDRESS		DATE OF BIRTH	SOCIAL SECURITY NUMBER
CITY, STATE, ZIP		SEX (M or F)	PATIENT'S RELATION TO RES
EMPLOYER		OCCUPATION	RESP PARTY ID (Office Use Only)

Primary Insurance

WHO IS THE PRIMARY INSURED PARTY (CHECK ONE)
[ ] Patient (same as above) [ ] Responsible Party (same as above) [ ] Other (complete below)

INSURANCE COMPANY NAME	COPAY AMOUNT	INSURED'S NAME (First Name, Middle Initial, Last Name		
INSURANCE COMPANY ADDRESS		INSURED'S ADDRESS, CITY, STATE, ZIP		
INSURANCE COMPANY CITY, STATE, ZIP		INSURED'S DATE OF BIRTH		
INSURANCE COMPANY PHONE NUMBERS		INSURED'S SOCIAL SECURITY NO.	INSURED'S SEX (M or F)	PATIENT'S RELATION TO INSURED
INSURED'S POLICY NUMBER	INSURED'S GROUP #	INSURED'S EMPLOYER		INSURED'S OCCUPATION

Secondary Insurance

WHO IS THE SECONDARY INSURED PARTY (CHECK ONE)
[ ] Patient (same as above) [ ] Responsible Party (same as above) [ ] Other (complete below)

INSURANCE COMPANY NAME		INSURED'S NAME (First Name, Middle Initial, Last Name)		
INSURANCE COMPANY ADDRESS		INSURED'S ADDRESS, CITY, STATE, ZIP		
INSURANCE COMPANY CITY, STATE, ZIP		INSURED'S DATE OF BIRTH		
INSURANCE COMPANY PHONE NUMBERS		INSURED'S SOCIAL SECURITY NO.	INSURED'S SEX (M or F)	PATIENT'S RELATION TO INSURED
INSURED'S POLICY NUMBER	INSURED'S GROUP #	INSURED'S EMPLOYER		INSURED'S OCCUPATION

Authorization and Acknowledgement

I / We hereby state that the above information is true and correct to the best of my / our knowledge. I / We authorize the above named practice to release any information acquired in the course of my treatment to my insurance company, employer, Physicians, institutions or third party payors, as required for certain claims filed. I understand I will be responsible for any collection fees if this account is delinquent.

Signature of Patient / Parent / Guardian _____ Printed Name _____ Date _____

I / We authorize direct payment to be made to the above named practice for any and all medical or surgical services rendered. I understand if any services or charges are not covered by my insurance carrier or my eligibility can not be verified, I am responsible for all charges incurred.

Signature of Patient / Parent / Guardian / Insured _____ Printed Name _____ Date _____