Amarillo Urgent Care
1915 Coulter Road
Amarillo, TX 79119

When it's Not an Emergency, But an Urgency

Welcome to Our Office!

Date: _____

Patient Information

Patients Name: _____ Sex: M _____ F _____
(Last Name) (First Name) (Middle)

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

May we call you at home? Yes No Work? Yes No May we leave a message? Yes No

Date of birth: _____ Age: _____ Marital Status: ___ S___M___D___W

Social Security: _____ Drivers License Number: _____

Email: _____

Occupation: _____ Employer: _____

Employer Address: _____

Primary Care Physician: _____ Phone: _____

Preferred Pharmacy: _____ Phone: _____

Emergency Notification

Name: _____ Relationship: _____

Address: _____ Apt. Number: _____

City: _____ State: _____ Zip: _____

Home Phone Number: _____

Spouse Information

Name: _____ DOB: _____ SS#: _____

Employer: _____ Phone Number: _____
Company, City

Insurance Information

Primary Plan: _____

Address: _____ City: _____ State: _____ Zip: _____

ID Number: _____ Group Name: _____ Group Number: _____

Co Pay Amount: _____ Effective Date: _____

Insurance Information

Secondary Plan: _____

Address: _____ City: _____ State: _____ Zip: _____

ID Number: _____ Group Name: _____ Group Number: _____

Co Pay Amount: _____ Effective Date: _____

Guarantor / Insurance Policy Holder

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security: _____ Home Phone: _____

Relationship to Patient _____

Emergency Contact Name: _____ Phone: _____

Payment in full is due at time of visit. We will be happy to file your insurance for reimbursement, if we are participating with the plan. It is your responsibility to be aware of coverage limits on your insurance plan. If you have any questions regarding your insurance coverage or payment, you must contact the insurance company directly.

AUTHORIZATION FOR TREATMENT: I consent to examination, treatment, and any procedures including emergency treatment deemed necessary and ordered by our physicians and I am personally responsible for any charges.

AUTHORIZATION FOR INSURANCE: I aurhorize release of any information concerning myself or my chiuld to my insurance company regarding treatment for services covered by my insurance plan.

AUTHORIZATION TO CONTACT ME: I hereby acknowledge taht Amarillo Urgent Care may contact me, either by phone, email, or mail to provide a reminder of an appointment, gather demographic or insurance information, or to inform me of services or events offered at the facility.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE: I hereby acknowledge that Amarillo Urgent Care has provided me a copy of their Privacy Notice.

I understand that I am legally responsible for payment of all bills for care given by Amarillo Urgent Care to myself or any of my dependents, regardless of insurance reimbursement.

_____ _____ _____

Patient or Responsible Party signature Date Please print name