FAMILY/CHILDREN'S URGENT CARE AND PEDIATRIC CLININC

1600 W SUNSET RD, STE A
HENDERSON, NV 89014
702-898-6400 PH 702-898-7032 FAX

3424 N BUFFALO DR, STE 100
LAS VEGAS, NV 89129
702-233-0174 PH 702-233-0176 FAX

ADULT PATIENT DEMOGRAPHICS:

NAME: ______________________ **SSN:** ______________________

DOB: ____________ **EMAIL:** ______________________

PHONE: D ____________ **E** ____________ **SEX: M/F MARITAL STATUS:** ____________

HOME ADRESS: ______________________

CITY: ____________ **STATE:** ____________ **ZIP:** ____________

EMERGENCY CONTACT: ____________ **RELATIONSHIP:** ____________

PHONE: ____________ **ADDRESS:** ______________________

EMPLOYED: Y/N EMPLOYER: ______________________

EMPLOYER ADRESS: ______________________

OCCUPATION: ______________________ **WORK PHONE:** ____________

PRIMARY INSURANCE: ______________________ **ID:** ____________

GROUP #: ____________ **SUBSCRIBER:** ____________

RELATIONSHIP: ____________ **SUBSCRIBER DOB:** ____________

RESPONSIBLE PARTY INFORMATION: ______________________

PHONE: ____________ **ADRESS:** ______________________

CITY: ____________ **STATE:** ____________ **ZIP:** ____________

PRIMARY CARE PHYSICIAN: ______________________

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS FOR PAYMENT. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. I AUTHORIZE DIRECT PAYMENT OF BENEFITS TO THE PHYSICIAN FOR SERVICES RENDERED. I REALIZE I AM RESPONSIBLE FOR PAYMENT OF CHARGES NOT COVERED BY INSURANCE. I CERTIFY THAT INFORMATION I HAVE REPORTED WITH REGARD TO MY INSURANCE COVERAGE IS CORRECT.

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SIGNATURE **DATE**