EXECUTIVE URGENT CARE AT INDIAN WELLS

PLEASE COMPLETE **ALL** INFORMATION

PATIENT INFORMATION

Name: First	Middle	Last	
Date of Birth:	SSN:	Main Phone:	
Mailing Address:		Sex: M ( ) F ( )	
City:	State:	Zip:	Marital Status: M ( ) S ( ) D ( ) W ( )
Primary Doctor:	Pharmacy:	E-Mail Address:	
Employer / School Name & Address:			
City:	State:	Zip:	Phone:
Emergency Contact:	Name:	Phone:	Relation:
How did you hear about us?	Signage ( ) Insurance ( ) Friend ( ) Doctor ( ) Internet ( ) Other(specify) :		

PARENT / GUARDIAN OR INSURER'S INFORMATION

Full Name:	Date of Birth:	
Address:	SSN:	
City:	State:	Zip:
Main Phone:	Relation to Patient:	Sex: M ( ) F ( )

PARENT / GUARDIAN / OTHER THAN INSURED'S INFORMATION

Full Name:	Date of Birth:	
Address:	SSN:	
City:	State:	Zip:
Main Phone:	Relation to Patient:	Sex: M ( ) F ( )

AUTHORIZATION

A photo ID is **required**. If you would like us to bill your insurance, a copy of your insurance card(s) is **required** at the time of registration. If for any reason you do not have your insurance card(s) for us to copy, you will be considered a **CASH PAY PATIENT**.

AUTHORIZATION TO PAY BENEFITS TO PROVIDER: I hereby authorize payment directly to the Executive Urgent Care of Indian Wells for the Medical Benefits for services rendered. I hereby authorize Executive Urgent Care of Indian Wells to release any and all information necessary to process this claim.

Signature:	Date: