SAND CANYON URGENT CARE

Patient Information

REASON FOR TODAYS VISIT _____

(Legal Name)
PATIENT NAME: _____ **DOB:** _____ **SOCIAL SECURITY** _____

Male _____ **Female** _____

STREET ADDRESS: _____

CITY, STATE & ZIP _____

HOME PHONE: _____ **WORK PHONE:** _____ **CELL PHONE** _____

PHONE NUMBER WHERE WE MAY LEAVE A CONFIDENTIAL MESSAGE _____

BEST FORM OF CONTACT: ____ **EMAIL** ___ **CELL PHONE** ___ **HOME PHONE** ____ **WORK PHONE** ____ **MAIL**

EMAIL ADDRESS: _____

EMPLOYER: _____**OCCUPATION :** _____

EMPLOYER STREET ADDRESS: _____

EMPLOYER CITY, STATE & ZIP CODE: _____

EMERGENCY CONTACT: _____ **PHONE NUMBER** _____ **RELATIONSHIP** _____

NAME OF INSURED :_____
(Policy Holder)

INSURED'S DATE OF BIRTH: _____ **INSURED'S SOCIAL SECURITY NUMBER:** _____

HOW DID YOU HEAR ABOUT OUR CLINIC? ☐ **YELLOW PGS** ☐ **INTERNET SITE**
☐ **FRIEND** ☐

☐ **MY EMPLOYER SENT ME HERE** ☐ **MY PRIVATE DOCTOR REFERRED ME**

PRIMARY CARE DOCTOR (NAME AND NUMBER): _____

WOULD YOU LIKE YOUR RECORDS FAXED TO YOUR DOCTOR? ____**YES** ____**NO**

Signature _____ Date _____