



**PATIENT INFORMATION (Please Print Clearly)**

Date \_\_\_\_\_

Patient Name:	Social Security#	Birth Date:	Age:
Street Address:	City, State	ZIP	Home Phone
	Work Phone:	Cell Phone:	Email:
Emergency Contact:	Relationship	Phone Number:	

**Primary Insurance - Policy Holder Information (a copy of your insurance card will be kept on file)**

Name (If Different From Patient)	Birth Date	Relationship to Patient
Employer:	Insurance Carrier	Effective Date

**Secondary Insurance (If Applicable)**

Name (If Different From Patient)	Birth Date	Relationship to Patient
Employer:	Insurance Carrier	Effective Date

**\*\*\*\*\* Payment and Release of Information Authorization \*\*\*\*\***

I hereby authorize Gwinnett Urgent Care to furnish the Medical and Insurance information concerning my visit and treatment for the purpose of Insurance Filing and Claim Processing. I direct the insurer to pay without equivocation, directly to Gwinnett Urgent Care, all benefits due as a result of this claim.

I am aware that, although covered by insurance, I am personally responsible for all charges. Gwinnett Urgent Care will make reasonable efforts to obtain payments from the insurance carrier.

All deductibles and Co-Pays are due at time of treatment. I authorize Gwinnett Urgent Care to keep my signature on file AND to charge my credit card with any balance of charges not paid by insurance 60 days past due.

\_\_\_\_\_  
Signature of Patient (or Guardian)

\_\_\_\_\_  
Date



Patient Health History

Name:	DOB:	Date:
Reason for Visit:		

**Drug Allergies**

**Current Medications**

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**Hospitalizations / Surgeries**

Reason	Date	Reason	Date

**Women Only: Any Chance You Could Be Pregnant?      Y      N**

**Medical History**

Asthma	Diabetes	Migraine Headaches
Anemia	Depression	Seizures
Arthritis	Heart Disease	Stroke
Acid Reflux	Hepatitis	Other:
Bleeding Disorder	High Cholesterol	Other:
Cancer	Hypertension	Other:

**Bad Habits**

Smoking:   N   Y   Pack/Day \_\_\_\_\_      Alcohol:   Never   Social   Daily

Patient Name: \_\_\_\_\_  
                             First                      Middle                      Last