



**PATIENT INFORMATION FORM** (Please Print Clearly) Date: \_\_\_\_\_

Patient Name:	Social Security#	Birthdate:	Age:
Street Address	City , State	ZIP	Home Phone
Drivers License #	Work Phone	Cell Phone	
Emergency Contact	Relationship	Phone#	

**Primary Insurance Verification – Policy Holder Information**

Name (if Different From Patient)	DOB	SSN	Relationship to Patient
Employer:	Insurance Carrier	Effective Date	Phone #
Group Number	ID Number		
Insurance Mailing Address	City, State	Zip	

**Secondary Insurance (If Applicable)**

Name (if Different From Patient)	DOB	SSN	Relationship to Patient
Employer:	Insurance Carrier	Effective Date	Phone #
Group Number	ID Number		
Insurance Mailing Address	City, State	Zip	

**\*\*\*\*Payment and release of information authorization\*\*\*\***

I hereby authorize Gwinnett Urgent Care to furnish information concerning my visit and treatment. I direct the insurer to pay without equivocation, directly to the physician, all benefits due him as a result of this claim. Although covered by insurance, I am aware that I am personally responsible for all charges. I agree to pay all costs and charges associated with my failure to pay my debt.

I hereby authorize Gwinnett Urgent Care to release the medical information contained in my chart to my insurance carrier for the purpose of conducting reviews, as necessary.

A 1.5% late fee is due and payable on all patient balances greater than 30 days past due.

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

\_\_\_\_\_  
Date