Gateway Urgent Care New Patient Welcome Sheet

How did you hear about us?

❑ **Friend** ❑ **Drive By** ❑ **Flyer** ❑ **TV / Radio / News** ❑ **Web** ❑ **Employer** ❑ **Insurance** ❑ **Other** _____

Date: _____ Time: _____

Why are you here today?

Reason for Visit: ❑ Urgent Care ❑ Work Injury ❑ Occupational Health ❑ Other_____

Is Injury work related? ❑ Yes ❑ No If yes, Date of Injury: _____ Time of injury: _____

Chief Complaint (Describe Illness or Injury) _____

Patient Information:

Last Name:_____ First Name:_____ Social Security: _____ - _____ - _____

Street Address: _____ Birth Date: _____ Age: _____

City, State, Zip: _____ Home Phone: _____

Email Address: _____ Work Phone: _____

Sex: ❑ Male ❑ Female Marital Status: ❑ Single ❑ Married DL #: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Pharmacy Name: _____ Address: _____ Phone:_____

Primary Care Physician Name: _____Phone: _____

Patient Employer or Guarantor:

Employer or Guarantor Name: _____ Department: _____

Street Address: _____ Employer Phone: _____

City, State, Zip: _____ Supervisors Name: _____

Other Address: _____ Guarantor DOB: _____

Occupation: _____ Employee #: _____

Insurance Information:

Is the insurance carrier responsible for your visit, your private insurance or your employer's workers compensation insurance?

❑ Private Insurance ❑ Employers Workers Comp Insurance Name of Insurance: _____

Assignment of Benefits - Financial Agreement:

I hereby authorize this office and its staff and doctors to examine and treat my condition as the doctors deem appropriate and I give authority for these procedures to be performed. I clearly understand and agree that all services rendered me are charge directly to me and that I am responsible for payment of services by this office and all outside laboratory or radiology services performed on my behalf. Should collection of past due amount become necessary, I will become responsible for all charges, fee and attorney fees. I (we) hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Patient / Guardian: _____ Date: _____

Consent to Treat a Minor: YOU MUST HAVE DOCUMENTATION OF GUARDIANSHIP AND/OR CUSTODY PAPERWORK WHEN BRINGING IN A MINOR

I (we) being the parents, guardian or custodian of the minor being:

Last _____ MI _____ First _____, Age _____, do hereby authorize, request, and direct this office, its doctors and staff to perform examinations, diagnostic, X-rays, laboratory tests, and any treatment that in their judgment is deemed advisable or is required while said minor child is under care of this office's doctors and staff until legal age. All charges for service and care given to said minor child will be charged directly to me (us) and I (we) will be personally responsible for payment of them. I (we) hereby authorize the doctor to release all information necessary to secure payments of benefits. I authorized the use of this signature on all insurance submissions.

Parent, Guardian, or Custodian Signature: _____Date _____

Relationship to Patient: _____Witness _____Date _____