Lincoln Urgent Care

PATIENT INFORMATION

First Name: ________________________________ MI: ______ Last Name: ________ __________________________

Date of Birth: ___/___/________ Age: _____ **SS#**: _____-_____-________ _____Male _____ Female

***If patient is a minor (under the age of 18) who may authorize treatment:

Name: ____________________________________ **Relationship**: ___________________________________

Ethnicity: _____ Asian _____ Black _____ Caucasian/White _____ Latino/Spanish _____ Other_____

CONTACT INFORMATION

Home Address: __________________________________ **City**: ____________________ **State**: ____ **Zip**: ________

Mailing Address/PO Box if different from above: ____

Home Phone: (____) _____ - _______ **Cell**: (_____) _____ - ______ **Email Address**: _________________________

Emergency Contact Name: _____________________________ **Phone**: __________________________________

Relationship: ______________ Permission to give Medical Information to Emergency Contact: ___ Yes ___No

INSURANCE INFORMATION

Primary Care Physician Name: ___________________________________ **Phone**: __________________________

Primary Insurance Name: _________________________________ **ID Number**: ____________________________

Secondary Insurance Name: _______________________________ **ID Number**: ____________________________

If Workers Compensation Case or Injury Case please provide the following information:

Insurance/Attorney Name: ____________________________ **Case ID Number**: ___________________________

Phone: ___________________________ **Fax**: ______________________________

PATIENT SIGNATURE: ____ **Date**: _____/ _____/ _____