Lincoln
Urgent Care

PATIENT INFORMATION

First Name: _____ MI: _____ Last Name: _____

Date of Birth: ___/___/_____ Age: _____ **SS#**: _____-_____-_____ Male___ Female___ Other ___

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

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

Name: _____ **Relationship**: _____

CONTACT INFORMATION

Home Address: _____ **City**: _____ **State**: ____ **Zip**: _____

Mailing Address/PO Box if different from above: _____

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

OK to leave message ___Yes ___No

Emergency Contact Name: _____ **Phone**: _____

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

Primary Care Physician Name: _____ **Phone**: _____

Your Pharmacy Name: _____ **Pharmacy Phone #:** (____) _____ -_____

How did you hear about us? (Circle One) Google Facebook Yahoo Website Friend Other

X PATIENT SIGNATURE: _____ **Date**: _____/ _____/ _____