LAKES URGENT CARE
When your health concerns can't wait.

Date: _____
PLEASE PRINT

Patient's Name: _____ Birth Date: ____/____/_____

Address: _____ ____ **M / F**

City: _____ State: _____ Zip: _____ SS#: _____

Home Phone: _____ Cell Phone: _____

E-Mail: _____ Fax: _____

Patient's Employer: _____ Work Phone: _____

Name of Insurance Policy Holder: _____

Policy Holder's Contract #:_____

Address: _____ City: _____ State: _____

Employer: _____ Phone: _____

SS#: _____ ***Policy Holder's*** **Date of Birth**: _____

Relationship to Patient: _____

Any Drug Allergies? _____

Latex allergy ? Yes ( ) No ( )

Who is Your Physician**?** _____ Phone: _____

Address _____

How did you hear about Lakes Urgent Care? Yellow Pages Street Sign Friend/Family
Your Doctor Advertisement Website

Referred to Lakes Urgent Care By: _____

Full payment is expected at the conclusion of your office visit. It is your responsibility to understand your insurance coverage and policy benefits. Having health insurance does not guarantee you will not have any additional payments which you must make. **Lakes Urgent Care bills ALL visits as an Office Visit and not as an Urgent Care or Emergency Department Visit.**

Patient/Parent/Guardian Signature: _____