QUEEN'S ISLAND URGENT CARE

PATIENT INFORMATION

OFFICE USE ONLY
DATE & TIME: ____________________ CLINIC LOCATION: __________________
PATIENT ACCOUNT #: ________________ STAFF INITIALS: __________________

FIRST NAME: _________________________________ M.I. ________ LAST NAME: ___________________________________

ALT / MAIDEN NAME: ________________________________ SOCIAL SECURITY NUMBER (SSN): _______________________

DATE OF BIRTH: _________________ AGE: ______ GENDER: ________________ MARITAL STATUS: ____________________

PERMANENT MAILING ADDRESS (PLEASE INCLUDE APT, SUITE, OR UNIT #):

_____________________________________ APT #: ______ CITY: ___________________ STATE: _______ ZIP: ___________

VISITING ADDRESS:

_____________________________________ APT #: ______ CITY: ___________________ STATE: _______ ZIP: ___________

CELL PHONE #: _______________________________________ HOME PHONE #: ____________________________________

MAY WE LEAVE MESSAGES ON PROVIDED PHONE NUMBERS (SECURE VOICEMAIL)? ☐ YES ☐ NO

SECURE EMAIL: QIUC SENDS BILLING STATEMENTS, RECEIPTS, AND/OR ACCOUNT NOTIFICATIONS VIA SECURE EMAIL. PER HIPAA COMPLIANCE, PROTECTED HEALTH INFORMATION WILL ONLY BE SENT VIA ENCRYPTED EMAIL.

EMAIL (PLEASE WRITE CLEARLY): ____

PREFERRED PHARMACY: ________________________________ HOW DID YOU HEAR ABOUT US? _____________________

DO YOU HAVE A PRIMARY CARE PHYSICIAN? ☐ YES – PCP NAME: ________________________________ ☐ NO

REASON FOR VISIT / SYMPTOMS: _____________________________________ ONSET / INJURY DATE: _________________

RESPONSIBLE PARTY / PARENT / GUARDIAN(S) FOR MINOR PATIENTS (UNDER 18)

NAME:______________________________ RELATIONSHIP TO PAT.:___________________DATE OF BIRTH: ______________

SSN: ________________ PHONE: ____________________________ EMAIL: ____

ADDRESS: ____________________________ CITY: ________________ STATE: ______ ZIP: ___________ ☐ SAME AS PATIENT

EMERGENCY CONTACT

NAME: _______________________________ RELATIONSHIP TO PATEINT: ____________________ DOB: ________________

PHONE NUMBER: _______________________________ EMAIL: ____

(NOTE: IF YOU WISH TO ALLOW YOUR EMERGENCY CONTACT ACCESS TO YOUR PROTECTED HEALTH INFORMATION, PLEASE LIST THEM ON THE "AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION" FORM INCLUDED IN YOUR REGISTRATION DOCUMENTS.)

BILLING INFORMATION

☐ **INSURANCE CARD(S) PROVIDED**

PRIMARY INSURANCE

INSURANCE COMPANY: _________________________________

POLICY ID #: ____

POLICY HOLDER NAME: _______________________________

RELATIONSHIP TO PATIENT: _____________ ☐ MALE ☐ FEMALE

POLICY HOLDER DOB: ______________ SSN: _______________

SECONDARY INSURANCE

INSURANCE COMPANY: _________________________________

POLICY ID #: ____

POLICY HOLDER NAME: _______________________________

RELATIONSHIP TO PATIENT: _____________ ☐ MALE ☐ FEMALE

POLICY HOLDER DOB: ______________ SSN: _______________

BY SIGNING BELOW, I CERTIFY ALL THE INFORMATION PROVIDED ABOVE IS TRUE AND CORRECT.

PATIENT/PARENT/GUARDIAN SIGNATURE: ____ **DATE:** ___________________