

ROCKY MOUNTAIN URGENT CARE

Patient's Full Legal Name _____
Street Address: _____
City _____ State: _____ Zip: _____
Home Telephone: (____) --- _____ Date of Birth ____ / ____ / ____ Sex: Male Female
Social Security #: _____ --- --- _____ Marital Status: Single Married Divorced Separated
Employer Name: _____ Work Phone: _____
Employer Address: _____ City: _____ State: _____ Zip: _____
Occupation: _____ Spouse's Full Legal Name: _____
Cell Phone: (____) --- _____
Can we leave messages regarding your care (i.e. lab results, x-ray results) at this number? Yes No

REASON FOR VISIT:

INSURED OR RESPONSIBLE PERSON OR PARENT INFORMATION: if the patient is not responsible for payment

Name of Person Who Carries the Insurance: _____ Relation to Patient: _____
Address (if different from patient): _____
City: _____ State: _____ Zip: _____
Home Telephone: (____) --- _____ Work Telephone: (____) --- _____
Social Security #: _____ --- --- _____ Date of Birth: ____ / ____ / ____ Sex: Male Female

PARENT #2 INFORMATION

Name: _____ Relationship to Patient: _____
Address (if different from patient): _____
City: _____ State: _____ Zip: _____
Home Telephone: (____) --- _____ Work Telephone: (____) --- _____
Social Security #: _____ --- --- _____ Date of Birth: ____ / ____ / ____ Sex: Male Female

INSURANCE INFORMATION

Insurance Name: _____ Group Number: _____
Address: _____ Policy Number: _____
City State Zip _____ Policyholder Name (who carries the insurance): _____
Telephone _____ Copayment: _____
Authorization or Referral #: _____

REFERRAL INFORMATION

Primary Care Physician: _____ Referring Physician: _____
How did you hear about our office?: My Doctor Newspaper Yellow Pages Drive By Mailer

EMERGENCY CONTACT: someone not living in your household

Name _____ Relationship to Patient: _____
Telephone: (____) --- _____

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS I understand that I am financially responsible and agree to pay all of the charges that are not paid by or billed to insurance or any other third party payer. I authorize payment directly to Aurora Health Care Services, PC for all benefits otherwise payable to me.

CONSENT AND DISCLOSURES: I voluntarily consent to treatment for myself and/or my dependents.

RELEASE OF INFORMATION: I authorize Aurora Health Care Services, PC to release (verbally or in writing) confidential medical information to any person or entity which may be liable to me or my Practitioner(s) for charges for this treatment, and for quality management, utilization review, transfer, and follow-up purposes. I understand that a copy of this agreement may be used with the same effectiveness as an original.

Signature of Patient/
Responsible Party: _____ Date: ____ / ____ / ____