CLEARCHOICEMD® URGENT CARE

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Date: _____ CCMD Staff Member: _____

Last Name:_____First Name: _____

Date of Birth:_____SS#:_____Marital Status: _____

Mailing Address:_____Sex: M / F

City:_____State: _____ Zip Code: _____

Home Phone:_____Cell Phone:_____Work Phone: _____

Email: _____

Emergency Contact:_____ Phone:_____Relationship:_____

Guarantor (person responsible for bill, if applicable):_____DOB:_____

Guarantor Address (if different from patient):_____Relationship:_____

Insurance Policy Holder (if other than patient):_____

Insurance Policy Holder Date of Birth: _____

Primary Care Provider Name: _____

Pharmacy and Location: _____

Reason for Visit: _____

How did you hear about us:_____(Please be specific)

Please answer the following three questions:

1. **Do you want your records sent to your Primary Care Provider? Yes or No**

2. **I have read and understand the Consent for Treatment, Controlled Medication, Assignment of Benefits, Confidentiality, Complaint Procedure, Release of Information, Bill of Rights and Privacy Practice Policies.**
   Would you like a copy of these policies? Yes or No

3. **Follow-up Communication: We may contact you after your visit in order to request feedback on your experience. May we contact you via text message? Yes or No**

Patient/Guardian Signature:_____Date:_____

Patient/Guardian Printed Name: _____