Urgent Medical Care
412 South Broadway, Hicksville, NY 11801
Phone: (516) 938-1550 / Fax: (516) 938-1554 / Email: www.statcarewalkin.com

DATE: ____________________

PATIENT ACQUAINTANCE FORM

PATIENT'S NAME: LAST: ______ **FIRST:** ______ **MI:** ______

ADDRESS: ______ **CITY:** ______ **STATE:** ______ **ZIP:** ______

HOME PHONE: ______ **CELL PHONE:** ______ **WORK PHONE:** ______ **EMAIL:** ______

SOCIAL SECURITY #: ____ - ____ - ____ **Have you ever been seen in here before?** ☐ **Y** ☐ **N**

AGE: ______ **DATE OF BIRTH:** (MM/DD/YYYY) ___ / ___ / ___ **SEX:** ☐ **F** ☐ **M** **MARITAL STATUS:** **M** **D** **Sep** **Single**

OCCUPATION: ______ **EMPLOYER:** ______

EMPLOYEE ADDRESS: ______ **CITY:** ______ **STATE:** ______ **ZIP:** ______

PRIMARY CARE PHYSICIAN: ______ **PHYSICIAN TELEPHONE:** ______

PRIMARY CARE PHYSICIAN'S ADDRESS: ______ **CITY:** ______ **STATE:** ______ **ZIP:** ______

NEXT OF KIN OR EMERGENCY CONTACT: ______ **TEL. #** ______

NAME OF SPOUSE: ______ **SPOUSE'S SS#:** ______

SPOUSE'S DATE OF BIRTH: ______ **SPOUSE'S EMPLOYER:** ______

SPOUSE'S EMPLOYER ADDRESS: ______ **WORK TEL #:** ______

MEDICAL INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: ______ **NAME OF POLICY HOLDER:** ______

TYPE OF PLAN: ______ **EFFECTIVE DATE:** ______

ID NO: ______ **GROUP NO.** ______

SECONDARY INSURANCE COMPANY: ______ **NAME OF POLICY HOLDER:** ______

TYPE OF PLAN: ______ **EFFECTIVE DATE:** ______

ID NO. ______ **GROUP NO.** ______

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize and direct the above named clinical practice, having treated me, to release to government agencies, insurance carriers, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment and I hereby assign, transfer, and set over to the above name clinical practice sufficient monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers, or others who are financially liable for my medical care to cover the costs of the care and treatment rendered to myself or my dependent in said practice.

____

PATIENT OR REPOSNSIBLE PARTY SIGNATURE **DATE**