Sacramento URGENT CARE
Your Walk-In Medical Clinic

**Reason for Visit:**______________________________________________

**Patient Information**

Last Name:______________________ First Name:______________________

Social Security Number:______________ Date of Birth:______________ Sex: Male/Female

Address:______________________ City:________________ State:__________

Zip Code:________ Phone Number:______________ Cell Number:________________

E-mail Address:______________________________________________

Employer:______________________________ Phone Number:______________

Address:______________________________________________

**Guarantor for Minor: Authorization to treat minor**

Last Name:______________________ First Name:______________________

Social Security Number:______________ Date of Birth:______________ Sex: Male/Female

Address:______________________ City:________________ State:__________

Zip Code:________ Phone Number:______________ Relationship:________________

***Signature of Parent or Legal Guardian:***______________________ ***Date:***__________

**Insurance Information**

Name of Primary Insurance:______________________ Policy Number:______________

Name of Primary Insured:______________________________ Date of Birth:__________

Address:______________________ City:________________ State:__________

Zip Code:________ Phone Number:______________ Relationship:________________

Name of Secondary Insurance:____________________ Policy Number:______________

Name of Primary Insured:______________________________ Date of Birth:__________

Address:______________________ City:________________ State:__________

Zip Code:________ Phone Number:______________ Relationship:________________

**Primary Care Physician**

Name of Doctor:______________________________ Phone Number:______________

Location:______________________________ Fax Number:________________

**Please complete the back of this form**

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**Emergency Contact**

Last Name:__________________________First Name:________________________________

Phone Number:_________________Cell Number:_____________Relationship:_____________

## Consent for Treatment

I consent to the performance of all routine medical care and treatment (e.g. tests, therapy, medical treatment or procedures, etc.) which may be performed as deemed necessary by and under the general and special instructions of the physician and/or authorized health care providers of Sacramento Urgent Care.

## Release of Information

I agree that, to the extent necessary to determine liability for payment and to obtain reimbursement, or as otherwise permitted or required by law, Sacramento Urgent Care may disclose any portion of my/the patient's medical records including but not limited to, information about patient's diagnosis and/or treatment relating to medical, mental health, developmental disability, and/or substance abuse treatment to any government agency or corporation including, but not limited to, insurance companies, employers, or health service plans to ensure coordination of my/the patient's ongoing care and treatment. I also release any medical information to the patient's primary care physician or any consulting physicians or health care providers participating in my/the patient's care.

## Privacy Notice: HIPAA

By signing this section, you acknowledge understanding of the above Notice of Privacy Practices of Sacramento Urgent Care provides and information about how we may use or disclose your protected health information. We encourage you read it fully.

***Print name of Patient:***____________________________________________________________

***Print name of Person signing below:***_________________________***Relationship:***_____________

***Signature of Patient or Legal Guardian:***_____________________________***Date:***_____________

## Authorization

The undersigned certifies that he/she has read the information noted above and has been given the opportunity to have questions answered fully regarding the above information and to his/her satisfaction, and has the option to receive a copy of this agreement upon request. The undersigned further certifies that he/she is 1) the patient 2) the patient's legal representative or 3) is duly authorized by the patient as the patient's general agent to execute the above and accepts its terms.

***Print name of Person signing below:***_________________________***Relationship:***_____________

***Signature of Patient or Legal Guardian:***_____________________________***Date:***_____________

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**How did you hear about Sacramento Urgent Care?**

[ ] Monument Sign [ ] Google/Yahoo Search [ ] Yellow pages [ ] Local News

[ ] Friend/Relative [ ] Pocket Newspaper [ ] Doctor/Insurance [ ] Other