MARTINSVILLE URGENT CARE

SECTION 1

Patient First Name_____ Middle_____ Last_____

Mailing Address_____

City _____State ___ Zip Code _____ Social Security #_ _ _ -_ _-_ _ _ _

Date of Birth _____ Primary Phone#_____ Cell Phone #_____

Email_____ Marital Status _____

Gender _____ Race _____Circle one: HISPANIC or NONHISPANIC

Family Physicians Name _____

Physicians Phone # _____ May We Send Physician Your Records? _____

Reason for Todays Visit_____

Pharmacy You Prefer & Location_____

Occupation_____ Employer_____

SECTION 2

Where did you hear about Martinsville Urgent Care? (Pick only one)

___Radio	___Drive-by	___Friend/Relative	
___Billboard	___Internet	___Existing Patient	
___Newspaper	___Baseball Billboard	___Television	
___Doctor Referral	___Phonebook	___Work	___Other

Insurance Holders Name: _____
(Last Name) (First Name)

Mailing Address _____

_____

Phone#:_____
Social Security #:_____
Date of Birth_____

Gender _____Male _____Female Relationship to patient: _____Parent _____Spouse

Employer _____ Employers Phone # _____

IN CASE OF EMERGENCY, PLEASE CONTACT:
NAME: _____
RELATIONSHIP: _____
PHONE NUMBER: _____

By signing below, I acknowledge that I have been provided with a copy or read the Martinsville Urgent Care Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by Martinsville Urgent Care and how I may obtain access to and control this information. Copy is available to you upon request.

By signing below, you also expressly consent and agree that, in order to discuss or service your account(s) (the "Accounts") or to collect amounts you may owe, Martinsville Urgent Care and its officers, agents, affiliates, employees, and any affiliated or associated service providers and any third party debt collection agency associated therewith (collectively "We") may contact you by telephone at any telephone number associated with the Accounts, including wireless telephone numbers, which could result in charges to you. You expressly consent and agree that we may also contact you by sending text messages, emails, using any e-mail address you provide to us or by pre-recorded or artificial voice or voice messages, automatic dialing methods, systems, or devices and pre-recorded or artificial voice prompts at any telephone number associated with the Accounts, including wireless or mobile telephone numbers, regardless of whether you incur charges as a result.

X _____

Date: _____

Please list who you want to have access to your medical information:

1._____

2._____

THIS SECTION WILL BE COMPLETED IF THE WRITTEN ACKNOWLEDGEMENT NOT OBTAINED We have made a good faith effort to obtain an individual's acknowledgement, but the acknowledgement was not obtained for the following reason(s):
___The individual refuses to sign or otherwise fails to provide an acknowledgement
___The individual was mailed a copy of the Notice and did not mail back his or her receipt of acknowledgement.

___Other_____

Completed by
_____Date_____.