Patient Information

DOCTOR OF RECORD
Tammie D Adams PA C

AMC Urgent Care

PATIENT NAME (First Name, Middle Initial, Last Name)	PATIENT ID (Office Use Only)	DATE OF BIRTH	AGE	PRIMARY PHONE (HOME)	SECONDARY PHONE (WORK/CELL)
ADDRESS		SOCIAL SECURITY NUMBER		SEX (M or F) [ ]M [ ]F	MARITAL STATUS [ ]Married [ ]Single [ ]Other
CITY, STATE, ZIP		EMERGENCY CONTACT PERSON		RELATIONSHIP TO PATIENT	CONTACT PHONE
EMPLOYER		OCCUPATION		PATIENT E-MAIL ADDRESS	
REFERRING DOCTOR NAME & ADDRESS					
PRIMARY CARE DOCTOR NAME & ADDRESS					

Responsible Party

RESPONSIBLE PARTY NAME (First Name, Middle Initial, Last Name)		
ADDRESS	DATE OF BIRTH	SOCIAL SECURITY NUMBER
CITY, STATE, ZIP	SEX (M or F)	PATIENT'S RELATION TO RESP
EMPLOYER	OCCUPATION	RESP PARTY ID (Office Use Only)

Primary Insurance

WHO IS THE PRIMARY INSURED PARTY (CHECK ONE)
[ ] Patient (same as above) [ ] Responsible Party (same as above) [ ] Other (complete below)

INSURANCE COMPANY NAME	COPAY AMOUNT	INSURED'S NAME (First Name, Middle Initial, Last Name)		
INSURANCE COMPANY ADDRESS		INSURED'S ADDRESS, CITY, STATE, ZIP		
INSURANCE COMPANY CITY, STATE, ZIP		INSURED'S DATE OF BIRTH		
INSURANCE COMPANY PHONE NUMBERS		INSURED'S SOCIAL SECURITY NO.	INSURED'S SEX (M or F)	INSURED'S RELATION TO PATIENT
INSURED'S POLICY NUMBER	INSURED'S GROUP #	INSURED'S EMPLOYER		INSURED'S OCCUPATION

Secondary Insurance

WHO IS THE SECONDARY INSURED PARTY (CHECK ONE)
[ ] Patient (same as above) [ ] Responsible Party (same as above) [ ] Other (complete below)

INSURANCE COMPANY NAME		INSURED'S NAME (First Name, Middle Initial, Last Name)		
INSURANCE COMPANY ADDRESS		INSURED'S ADDRESS, CITY, STATE, ZIP		
INSURANCE COMPANY CITY, STATE, ZIP		INSURED'S DATE OF BIRTH		
INSURANCE COMPANY PHONE NUMBERS		INSURED'S SOCIAL SECURITY NO.	INSURED'S SEX (M or F)	INSURED'S RELATION TO PATIENT
INSURED'S POLICY NUMBER	INSURED'S GROUP #	INSURED'S EMPLOYER		INSURED'S OCCUPATION

Authorization and Acknowledgement

Assignment of Benefits * Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made to **AMC Urgent Care** and any assisting physicians, for the services rendered. I understand that I am financially responsible for all charges whether of not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fee. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Date:____________________ **Your Signature: ____**