Kashat Urgent Care

Please print Today's Date _____/_____/_____ Soc. Sec. # _____
Patient
Name: Last _____First _____ M.I ____Date of Birth _____

Address _____ City _____State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____ Marital Status ____ Sex M F

Race _____ Ethnicity _____ Language _____

Do you authorize us retrieving medications history from the pharmacy? □ Yes □ No

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Electronic prescription service

Name of the pharmacy _____ Phone _____

Address _____ _____ Zip _____
(CROSS STREETS)

If we have scheduled appointment for you and you are unable to keep this appointment, please give us 24 hours advance notice. Failure to do so may result a $25.00 missed appointment charge.

IF YOUR ACCOUNT GOES TO COLLECTION A 30% COLLECTION FEE WILL BE ADDED.

COPY FRONT & BACK OF INSURANCE CARD

Insurance name _____ Phone _____

Contract Number _____ Group _____

Service or Benefit Code _____ Effective Date _____

Subscriber _____ **Subscribers Date of Birth** _____

Insurance Release

I understand that I am financially responsible for all charges whether or not paid by my Insurance. I hereby certify that I provide my complete insurance information. I also understand it is my responsibility to notify Maplecrest Medical Group with any changes regarding my insurance coverage.
I request payment of authorized Medicare, Blue Cross or Independent insurance benefits to be made either to me or on my behalf to Maplecrest Medical Group for any services furnished to me by them. I authorize any holder of medical information about me to release to the Health Care Financing Administration and agents any information needed to determine these benefits or the benefits payable for the related services.

Sign_____ Date_____

INSURED OR AUTHORIZED PERSON

Emergency Contact: Nearest relative or friend
Name _____ Relation _____
Phone _____ □Home □Cell

How did you hear about our office? _____