NEW PT / EST PT

**OFFICE USE ONLY:**

PRIVATE / WORKER'S COMP / EPS / AUTO

**TIME GIVEN: __________**
**TIME REC'D: __________**

**DATE OF SERVICE: ________________________________**

***Above Urgent Care Center***
***8891 N Central Ave ~ Montclair CA 91763***
***909-297-3361 ~ F 909-621-1397***

**REASON FOR YOUR VISIT: ____________________________________________________**

**ATTENTION PATIENTS: PLEASE FILL OUT ALL SHADED AREAS**

**PATIENT INFORMATION**

**LAST NAME:** ________________________________ **FIRST NAME:** ________________________________ **MI:** _____

**DATE OF BIRTH:** / / **GENDER:** MALE FEMALE **SOCIAL SECURITY NUMBER:** - -

**AGE:**__________________________ **HEIGHT:**______________ **WEIGHT:**________________

**HOW DID YOU HEAR ABOUT US ?:** INTERNET / PCP / NEWSPAPER / PHONE BOOK / OTHER:____________________________

**MARITAL STATUS:** SINGLE MARRIED DIVORCED WIDOWED **PREFERRED LANGUAGE:** *ENGLISH / SPANISH / OTHER*

**EMAIL:**______________________________

**RACE:**____________________

**ETHNICITY:**______________________

**ADDRESS:** ____________________________________

**CITY:** ______________________**STATE:**_______ **ZIP:**______

**HOME PHONE:**______________________________

**WORK PHONE:**______________________________________

**CELLPHONE:**________________________________

**FAX:**____________________________________________

**PRIMARY CARE PHYSICIAN:** ________________________________

**PHN#:** ________________________

**OFFICE USE ONLY:** PAID (AMT):________
CASH / CHECK
AMEX / MC / VISA / OTHER

SCANNED

**OFFICE USE ONLY:**

NEW PT / EST PT

PRIVATE / WORKER'S COMP / EPS / AUTO

**TIME GIVEN: __________**
**TIME REC'D: __________**

## EMPLOYER INFORMATION

**EMPLOYER NAME: ____________________________________________________**

**EMPLOYER PHONE: ________________________________**

**EMPLOYER ADDRESS:________________________________________CITY: ____________________________STATE:________ ZIP:________**

## GUARANTOR INFORMATION (*PLEASE COMPLETE THIS SECTION IF THE PATIENT UNDER 18*)

**CONTACT NAME: ________________________________________**

**RELATIONSHIP TO PATIENT: ______________________________________**

**D.O.B.: ________________________________**

**SOCIAL SECURITY#: ______________________________________________________________**

**ADDRESS:______________________________________________ CITY:_________________________STATE:____________**

**ZIP: __________**

**HOME PHONE: ___________________________________________**

**WORK PHONE: ________________________________________________**

## INSURANCE

**PRIMARY INSURED ID #:______________________________________**

**INSURANCE NAME:__________________________________________**

**INSURED LAST NAME:________________________________________**

**FIRST NAME:_______________________________________________**

**D.O.B.:________________________________**

**SOCIAL SECURITY#: _______________________________________________________________**

**RELATIONSHIP TO THE PATIENT:** ***SELF SPOUSE PARENT STEP PARENT GUARDIAN GRAND PARENT CHILD OF*: ________________________**

**SECONDARY INS ID#: ____________________________________**

**SECONDARY INS NAME: __________________________________________**

**OFFICE USE ONLY:** PAID (AMT):________
**CASH / CHECK**
**AMEX / MC / VISA / OTHER**

**SCANNED**