



Reason for today's visit: \_\_\_\_\_

Patient's Name: \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_  
Street Apt. # City State Zip

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ SSN: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Preferred Language: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Allergies to medications, shellfish and latex: \_\_\_\_\_

In Case of an Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Address: \_\_\_\_\_

Employer's Phone: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

**INSURANCE: \*Items In Red Are Required Fields**

Primary Insurance: \_\_\_\_\_ \*Subscriber Name: \_\_\_\_\_

Subscriber ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

\*Subscriber DOB: \_\_\_\_\_ \*Subscriber SSN: \_\_\_\_\_

\*Relationship to Subscriber: \_\_\_\_\_

\*Subscriber Address (if different): \_\_\_\_\_

Street Apt # City State Zip

Secondary Insurance: \_\_\_\_\_ Subscriber Name: \_\_\_\_\_

Subscriber ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber DOB: \_\_\_\_\_

Relationship to Subscriber: \_\_\_\_\_

**IF MINOR:**

Mother's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

SSN: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_

Email Address: \_\_\_\_\_

Father's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

SSN: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_

Email Address: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

**IS THIS RELATED TO A WORK INJURY OR CAR ACCIDENT: Yes \_\_\_\_\_ No \_\_\_\_\_**

DOI: \_\_\_\_\_ Claim #: \_\_\_\_\_ Adjuster's Name: \_\_\_\_\_

Adjuster's Phone Number: \_\_\_\_\_

Insurance Name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

**THIS IS TO CERTIFY THAT ALL OF THE ABOVE INFORMATION IS CORRECT AND I TAKE FULL RESPONSIBILITY FOR ALL CHARGES INCURRED BY ME (CHILDREN), AND I HAVE READ AND UNDERSTOOD THE ABOVE:**

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**RELATIONSHIP TO PATIENT:** \_\_\_\_\_

May we make a follow-up call to you tomorrow? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, may we leave a message on your answering machine? Yes \_\_\_\_\_ No \_\_\_\_\_

**How did you learn about us?**

Family doctor \_\_\_\_\_ Family member \_\_\_\_\_ Friend \_\_\_\_\_ Neighbor \_\_\_\_\_

Billboard \_\_\_\_\_ Brochure/Flyer \_\_\_\_\_ Mail out/Door hanger \_\_\_\_\_

Just driving by the building \_\_\_\_\_ Web site \_\_\_\_\_

Other: \_\_\_\_\_

Submit will not work if you are using a web-based e-mail like Yahoo or Gmail. If you are having trouble submitting this form, please fill it out and save it and either fax or e-mail it to us.

Phone: 210-493-4357 Fax: 210-493-4355 E-mail: reception@impacturgentcare.com