Patient Information

Race: □White □American Indian or Alaska Native □ Asian □ Black or African American □Native Hawaiian or Other Pacific Islander □ Other

Preferred Language: ____________________________________ **Ethnicity:** □ Non Hispanic □Hispanic or Latino

Last Name: ______________________________ **First Name:** ______________________________ **Middle Initial:** _____________

Age: _____ **DOB:** ___________ **Sex: M F** **SS#:**_____________________ **Email:** ________________________________

Marital Status: _____________________ **Person Responsible for account:** ____

Address: ____

Permanent (If P.O. Box please provide street address also)

City: ____ **State:** __________________________ **Zip:** ____________________________

Home Phone: ___________________________ **Work:** _________________________ **EXT**____ **Cell:** __________________________

***Temporary Address*:** ____

City: _____________________________ **State:** ____________________ **Zip:** ________ **Temporary Phone:** ___________________

Emergency Contact ____________________________________ **Phone#** _________________ **Relationship** _________________

Family Doctor/Internist: ____ **Phone#** ______________________________

Employer: ____ **Phone:** __________________________ **EXT**______

Employer's Address: ____ **Years with Employer:** __________

Spouse's Name: __________________________________ **Date of Birth:** _____________ **Spouse's SS#:** ___________________

Spouse's Employer: ____ **Employer Phone#:** __________________________

If proper insurance information is not provided on the date of service, our office is not responsible for filing back charges. Please be advised that it is *your responsibility* to be aware of the benefits that your medical plan provides.

PRIMARY INSURANCE COMPANY	**SECONDARY INSURANCE COMPANY**
Company: ____________________________________	Company: ____
Policy#: ______________________________________	Policy#: ____
Group#: ______________________________________	Group#: ____
Policy Holder: ________________________________	Policy Holder: _____________________________________
Policy Holder DOB: ___________________________	Policy Holder DOB: _________________________________
Phone#: _____________________________________	Phone#: ____

****Please indicate the lab your insurance co. uses: ___Quest ___Lab One ___Labcorp ___Wuesthoff ___Health First**
I understand that if my choice for *LAB DIRECTIVE is incorrect, I am financially responsible for the bill that the lab sends me. If no Lab chosen we will send to Quest Laboratory automatically.

I, ___________________________________ hereby assign all medical benefits, to include major medical benefits to which I am entitled including Medicare and other government sponsored programs, private insurance, and any other health plans to **D. Badolato P.A./Premier Urgent Care of Brevard, LLC**. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize release to my insurance carrier, employer, and referring physician any information needed including diagnosis and records of any treatment or examination rendered to me to process this claim. Lifetime signature authorization. This authorization and assignment are to be continuing, remaining in force until revoked in writing by the undersigned for services beginning:

Patient/Guardian Signature: ____ Date: ____________________________