Ventura Urgent Care
a member of the visit health network.

PATIENT INFORMATION SHEET

ACCOUNT NUMBER

PATIENT REGISTRATION – PLEASE PRINT

PATIENT NAME: _____ DATE OF BIRTH: ____/____/____ SEX: M F
LAST FIRST MIDDLE

ADDRESS: _____
STREET APARTMENT # CITY STATE ZIP CODE

HOME PHONE #: (_____)_____-_____ CELL PHONE #: (_____)_____-_____ SOCIAL SECURITY #: _____-_____-_____

EMAIL ADDRESS: _____ DRIVERS LICENSE #: _____

PREFERRED METHOD OF COMMUNICATION: ☐ EMAIL ☐ CELL PHONE ☐ HOME PHONE ☐ MAIL

MARITAL STATUS: ☐MARRIED ☐SINGLE ☐DIVORCED ☐WIDOWED ☐OTHER PREFERRED LANGUAGE: _____

EMPLOYER NAME: _____ EMPLOYER PHONE #: (_____)_____-_____

ADDRESS: _____
STREET CITY STATE ZIP CODE

REASON FOR VISIT: _____

ETHNICITY (CHECK ONE): ☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO ☐ DECLINE TO PROVIDE ☐OTHER

RACE (CHECK ALL THAT APPLY): ☐ AMERICAN INDIAN/ALASKAN NATIVE ☐ ASIAN ☐ BLACK/AFRICAN AMERICAN ☐ NATIVE HAWAIIAN/OTHER PACIFIC ISLAND ☐ WHITE

SPOUSE OR PARENT (IF PATIENT IS A MINOR)

NAME: _____ DATE OF BIRTH: ____/____/____ RELATIONSHIP TO PATIENT: _____
LAST FIRST MIDDLE

ADDRESS: _____
(IF DIFFERENT FROM ABOVE) STREET APARTMENT # CITY STATE ZIP CODE

PRIMARY PHONE #: (_____)_____-_____ DRIVERS LICENSE #: _____ SOCIAL SECURITY #: _____-_____-_____

EMAIL ADDRESS: _____

EMPLOYER INFORMATION

EMPLOYER NAME: _____ EMPLOYER PHONE #: (_____)_____-_____

ADDRESS: _____
STREET CITY STATE ZIP CODE

INSURANCE INFORMATION

INSURANCE COMPANY	INSURED'S NAME
STREET ADDRESS	INSURED'S DATE OF BIRTH
CITY STATE ZIP CODE	INSURED'S SOCIAL SECURITY #
POLICY # GROUP #	RELATIONSHIP TO PATIENT: ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER

PRIMARY CARE PHYSICIAN: _____ PHONE NUMBER: (_____)_____-_____

PREFERRED PHARMACY: _____ PHONE NUMBER: (_____)_____-_____

PREFERRED HOSPITAL: _____ PHONE NUMBER: (_____)_____-_____

EMERGENCY CONTACT: _____ PHONE NUMBER: _____ RELATIONSHIP: _____

BENEFIT ASSIGNMENT & ACKNOWLEDGMENT OF FINANCIAL RESPONSIBILITY

All visits must be paid for at the time of service. We will bill your insurance company as a courtesy if satisfactory proof of insurance is supplied, and only if your required co-payment is made at the time of the service. **Responsibility for payment of all charges, however, rests at all times with the responsible party**. By you signing this form, the insured assigns all insurance benefits to Ventura Urgent Care Center and authorizes the Insurance Co. to make payment directly to Ventura Urgent Care for services provided. **All dispensed medications must be paid for at the time of service.**

CONSENT FOR TREATMENT

THE UNDERSIGNED CONSENTS TO:

(1) BE TREATED AT VENTURA URGENT CARE CENTER
(2) THE RELEASE OF INFORMATION FROM MEDICAL RECORDS TO ANY INSURANCE CARRIER OR ORGANIZATION REQUIRING SAME.

Signature of Patient/Insured _____ Date _____