Brazos Valley Urgent Care

Phone: 979-764-2882 || Fax: 979-764-2828

REASON FOR VISIT: _____

Did this happen at work? ☐ Y ☐ N Motor Vehicle Accident? ☐ Y ☐ N

PERSONAL INFORMATION

Name:	**Sex:** ☐M ☐F	**Date of Birth:**
Social Security No.:	**Marital Status:** ☐ S ☐ M ☐ D ☐ W	
Billing Address:	City/State/Zip:	
Other Address:	City/State/Zip:	
Home No.: ( )	Mobile No.: ( )	
Employer:	Work Phone: ( )	
Employer's Address:	City/State/Zip:	

EMERGENCY CONTACT

Name:	Relationship:	Phone: ( )

PRIMARY CARE DOCTOR

Name:	Doctor's Phone No.: ( )

RESPONSIBLE PARTY INFORMATION (If over 18, go to next section.)

Name:	Relation to patient:
Social Security No.:	Phone No.: ( )
Employer:	Employer Phone No.: ( )

INSURANCE INFORMATION (*INSURANCE CARD REQUIRED AT TIME OF SERVICE)*

Primary Insurance Co.:	**Secondary** Insurance Co.:
I.D.:	I.D.:
Group No.:	Group No.:
Policy Holder's Information Only Below This Line	***Policy Holder's Information Only Below This Line***
Name:	**Name:**
Social Security No.:	**Social Security No.**
Date of Birth:	**Date of Birth:**
Employer:	**Employer:**
Relation to insured: ☐ Self ☐ I am the spouse ☐ I am a child/dependent ☐ I am an employee ☐ I am the significant other ☐ Other: _____	**Relation to insured:** ☐ Self ☐ I am the spouse ☐ I am a child/dependent ☐ I am an employee ☐ I am the significant other ☐ Other: _____

Release: I, the undersigned, understand that I am financially responsible for any amount not covered by my health insurance provider. I also authorize the practice to release to my insurance company or their agent, information concerning healthcare, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

I hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to Central Texas Osteopathic Medical Association, PA, DBA Brazos Valley Urgent Care. This assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information to secure payment.

I UNDERSTAND IT IS MY RESPONSIBILITY TO PAY ANY DEDUCTIBLE, CO-INSURANCE, OR OTHER BALANCE NOT PAID OR COVERED BY MY INSURANCE COMPANY AT THE TIME SERVICES ARE RENDERED.

I also hereby acknowledge that I have received and reviewed the Privacy Notice of Brazos Valley Urgent Care.

How did you hear about us? ☐ Google ☐ TV ☐ Radio ☐ Website ☐ Drive-by ☐ Referred by: _____

SIGNED: _____ **DATE:** _____/_____/_____

Patient; Parent, or Guardian Signature (if child is under 18 years old)