



Brazos Valley Urgent Care

2911 Texas Avenue South
Suite 103
College Station, Texas 77845



Reason for visit: _____ How did you hear about us? _____

PERSONAL INFORMATION

Name:	Sex: M F	Date of Birth:	Marital Status: S M D W
Social Security No:			
Address:		City/State/Zip:	
Permanent Address:		City/State/Zip:	
Home No.: ()		Mobile No.: ()	
Occupation:	Employer:	Work Phone: ()	
Employer's Address:		City/State/Zip:	
Spouse/Parent:		Home No.:	
Emergency Contact:		Phone Number: ()	

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:

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.

SIGNED: _____ DATE: _____

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