LANSING

Section 5. How did you hear about Lansing Urgent Care?

NOTIFY THE RECEPTIONIST IMMEDIATELY IF YOU FEEL YC

_____Billboard _____Phone Book _____Event _____Insurance _____LUC Website

_____Clinic Sign _____Friend/Relative _____Doctor _____(P S O R \ H U _____Facebook/Twitter

_____Internet _____Television _____Radio _____Movie Theater _____Other

PDWLHQW/DVW Name: _____ **P D W L H Qt / D V W Name:** _____ **MI:** _____

***HQHU** ____ **MaOH**____ **Female** **Date of Birth:** _____ **Social Security Number:** _____

Street Address: _____ **$SW** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____

Work Phone: _____ **Preferred Method of Contact (circle one): home cell work**

E-Mail$GGUHVV: _____

Emergency Contact: _____ ***(P H U J H Q F \ & R Q W D F W 3 K R Q H*** _____

3ULPDU&DUH3KLFLDQ _____ **3&33RE** _____ **3&3)D[** _____

:RXOGRXOLNHWR2SW,QRUHFHLYHELOOLQJWDWHPHQWVHOHFWURQLFDOOHV ____ **1R**

☐ _____

Section 2. Insura Q F H 6 X E V F U L E H U (Primary Card Holder Information) ± Add Secondary Insurance in Section 7

☐ ***If same as above check this box and go to section 3*** **Relationship to Patient:** _____

6 X E V F U L E H U 1 D P H _____ _____ **6 X E V F**

6 X E V F U L $ G G U H V V _____

6WUHHW$GGUHVV *City* *State* *Zip*

6 X E V F U L E H U V 6 R F L D O 6 H F X U L W \ 1 X P E H U **Insurance Co-pay Amount: $** _____

6HFWLRQ HDVRQ RU 2VLW

Reason for Visit: _____

A: Is this Dwork related L Q M X U ** ____ **Yes ____ **No** ***If you answered YES to A, please fill out the back of this page***

B: Is this visit Auto Accident Related: ____ **Yes** ____ **No**

C: Is this visit related to another accident: ____ **Yes** ____ **No** **$ F F L G H Q W 6 W D W H B B B B $ F F L G**

Section 4. 5 H V S R Q V L E O H 3 D U W \ Information **This section only needs to be filled out if the patient is a minor or depend Ht**

* The 5 H V S R Q V L E O H 3 D U W \ is the adult who presents for treatment. In the case of a minor it is the adult that accompanies the patient for treatment or who signed W K H $ X W K R U L] D W L R Q W R 7 U H D W 0 L Q R U) R U P

5 H V S R Q V L E O H 3 D U W \ 1 D P H _____ **Relationship to Patient:** _____

6 R F L D O 6 H F X U L W ** _____ **' D W H %LUWK _____ ***HQGHU*** **M** ____ **F**

$ G G U H V V _____ ***3 K R Q H*** _____

Street Address *& L W * *6 W D W H* *= L S*

Section 5. How did you hear about Lansing Urgent Care?

_____Billboard _____Phone Book _____Event _____Insurance _____LUC Website

_____Clinic Sign _____Friend/Relative _____Doctor _____(P S O R \ H U _____Facebook/Twitter

_____Internet _____Television _____Radio _____Movie Theater _____Other

FORM CONTINUED ON BACK OF THIS PAGE, PLEASE COMPLETE

LANSING URGENT CARE

Date: _____

Section 6. Employer Information – Section only required for work related illness or injuries.

Employer Name: _____

Contact Name: _____ **Contact Department:** _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Employer Phone: _____ **Extension:** _____ **Employer Fax:** _____

If Injury, Date of Injury: _____ **Claim Number (if applicable):** _____

Section 7. Secondary Insurance Information (Primary Card Holder Information)

☐ ***If same as patient name check this box and do not complete this section***

Relationship to Patient: _____

Insurance Card Holder: _____
Last Name *First Name* *M.I.*

Insured's Address: _____

Insured's Social Security Number: _____ **Insured's Phone:** _____

Insured's Date of Birth: _____

Section 8.

☐ ***If same as patient name check this box and do not complete this section***

Relationship to Patient: _____

Insurance Card Holder: _____
Last Name *First Name* *M.I.*

Insured's Address: _____

Insured's Social Security Number: _____ **Insured's Phone:** _____

Insured's Date of Birth: _____

Thank you for choosing Lansing Urgent Care, it is our pleasure to serve you!