



PLEASE PRINT AND COMPLETE ALL PARTS

PATIENT NUMBER _____ TODAY'S DATE ____/____/____

PLEASE HAVE YOUR DRIVERS LICENSE AND INSURANCE CARD AVAILABLE....THANKS

THE FOLLOWING INFORMATION REFERS TO **THE PATIENT ONLY**:

Patient Name _____
Address: _____ City _____ State _____ Zip _____
Home Phone () _____ Work Phone () _____ Employer _____
Date of Birth ____/____/____ Age _____ Sex _____ Social Security # _____
Emergency Contact _____ Phone Number () _____
Primary Care Physician: _____ Phone Number () _____

WE WILL SEND ALL MEDICAL RECORDS TO YOUR PRIMARY CARE PHYSICIAN UNLESS YOU MARK THIS BOX.

I do not wish for my medical records to be sent to my primary care physician.

PERSON/COMPANY RESPONSIBLE FOR PAYMENT TODAY:

SAME AS ABOVE

Name _____
Address _____ City _____ State _____ Zip _____
Home Phone () _____ Work Phone () _____ Employer _____
Social Security # _____ Date of Birth ____/____/____
Employer _____ Phone Number () _____

WHERE DID YOU HEAR ABOUT GUARDIAN URGENT CARE? (PLEASE CIRCLE ONE):

Radio • Clinic-Sign • Patient Referral • Internet • Dexonline • Billboard • Money-Mailer • Pocket Book • Convention Center
Westword • Phone Book • Friend • Event • Hotel • Insurance • King Soopers • Profile Ad • Relative • Work • Pharmacy
____ Doctor Referral → Name of Doctor _____ Tel # () _____

INSURANCE: (PLEASE COMPLETE THOROUGHLY)

Primary Insurance _____ Insured Person _____
Address: _____ City _____ State _____ Zip _____
ID/Policy Number # _____ Group _____
Secondary Insurance _____ Insured Person _____
Address _____ City _____ State _____ Zip _____
ID/Policy Number # _____ Group _____
Work Injury? What is the Claim #? _____ Date of Injury ____/____/____

CONSENT FOR TREATMENT: I, the patient named above, do request and consent to have GUARDIAN URGENT CARE, LLC and their employees, evaluate and treat the above patient for medical complaints and illnesses. This includes taking of medical information, evaluation by physical examination, obtaining of bodily fluids for laboratory testing, obtaining of X-Rays for diagnosis and the administration of medications for treatment. If, at any time, I do not wish to have these services rendered, I may simply state so and they will not be provided. All of my information will remain confidential. In addition, I acknowledge that I have received a copy of GUARDIAN URGENT CARE's Notice of Privacy Practices. I authorize the release of any medical information and payment of medical benefits to GUARDIAN URGENT CARE LLC for services necessary to process this claim. I agree to be responsible for any deductible, co-insurance, co-pay, or any other balance not paid by my insurance.

CONSENT FOR TEST INFORMATION: I give GUARDIAN URGENT CARE permission to communicate any future medical information to me by: **Telephone:** _____ **and/or** **mail** to my home address

By signing below, I understand this agreement between GUARDIAN URGENT CARE LLC AND THE UNDERSIGNED.

Patient Name _____

Patient Signature _____ Date ____/____/____

Relationship to patient ___self___ ___parent___ ___guardian___ ___other___