North Georgia Urgent Care
www.mynguc.com

Established Patient Demographic Form

Last Name:		First Name:		DOB:	
Address:					
City:		State:		Zip:	
Cell Phone:		Home Number:			

Has your insurance changed since your last visit? YES ____ NO ____ *if so, please present your new card to the front office staff.*

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize North Georgia Urgent Care to release my information required to process claims.

_____ _____

Patient / Guardian Signature **Date**

Please indicate below any CHANGES in your health history since your last visit.

Condition	Date of occurrence

Please indicate below any CHANGES in your family history since your last visit (mother, father, brother or sister)

Condition	Who and their age?

Please indicate your symptoms today.

What Pharmacy will you be using today? _____

_____