North Georgia Urgent Care
www.mynguc.com

PATIENT INFORMATION

Last Name:		First Name:	
Middle Name:		Nick Name:	
SSN:		Gender:	□ Male □ Female
Date of Birth:		Marital Status:	
Address:			
City:		State:	Zip:
Cell Phone:		Home Phone:	
Email:			

Primary Care Physician Name:	□None
PCP Practice Name:	
Emergency Contact Name:	
Relationship to Patient:	□ Mother □ Father □ Other (specify):
Emergency Contact Phone:	

RESPONSIBLE PARTY (If self, check self and skip to next section).

Relationship to Patient:	□ Self □ Mother □ Father □ Other (Specify):		
Last Name:		First Name:	MI:
SSN:	Gender □ M □ F	Date of Birth:	
Address:			
Email:			

SUBSCRIBER INFORMATION (If self, check self and skip to next section).

Relationship to Patient:	□ Self □ Mother □ Father □ Other (Specify):		
Subscriber Name:			
Subscriber Date of Birth:		Subscriber SSN:	
Subscriber Address:			

INSURANCE INFORMATION

Insurance Company:	
Group Name:	Group Number:
Member ID:	
Plan Types:	□ PPO □ POS □ HMO □ EPO □Indemnity □ Other
Medical Claims Address:	

Due to HIPAA regulations, we are required to have the name of the person we are authorized to discuss your healthcare issues, in the event of a critical matter or emergency. (For patients over 18)

Authorized Name Phone number Relationship

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:**