OFFICE USE ONLY	PT ID:	TIME:

SUPERIOR URGENT CARE
Excellence in Medical Service

PATIENT INFORMATION

LAST NAME:	FIRST NAME:	MIDDLE NAME:	DATE OF BIRTH:
SEX: ☐ M ☐ F	SSN:	CELL PHONE:	HOME PHONE:
MAILING ADDRESS:	APT #:	CITY:	STATE:
ZIP CODE:	EMAIL:		
PREFERRED NAME:	PREFERRED LANGUAGE:		

MARITAL STATUS:

☐ CHILD/ ADOLESCENT ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

PREFERRED METHOD OF CONTACT:

☐ HOME PHONE ☐ CELL PHONE ☐ EMAIL ☐ MAIL

MAY WE LEAVE MESSAGES ON YOUR ANSWERING MACHINE:

☐ YES ☐ NO

OCCUPATION:	EMPLOYER:	EMPLOYER PHONE:	
EMERGENCY/NEXT OF KIN CONTACT:	RELATIONSHIP:	EMERGENCY/NEXT OF KIN PHONE:	
EMERGENCY/NEXT OF KIN ADDRESS:	CITY:	STATE:	ZIP CODE:

RACE/ ETHNICITY:

☐ ALASKAN INDIAN/ NATIVE ALASKAN ☐ ASIAN ☐ MIDDLE EASTERN/ INDIAN ☐ AFRICAN AMERICAN/ BLACK
☐ NATIVE HAWAIIAN/ PACIFIC ISLANDER ☐ CAUCASIAN/ WHITE ☐ HISPANIC/ LATINO ☐ OTHER: _____

HOW DID YOU HEAR ABOUT US?

☐ SIGNAGE/ DRIVE BY ☐ FLYER/ COUPON ☐ RELATIVE ☐ EXISTING PATIENT ☐ GOOGLE ☐ SUPERIOR URGENT CARE STAFF
☐ FRIEND ☐ YELP ☐ BUSINESS RELATIONSHIP ☐ INSURANCE ☐ INTERNET ☐ MAILER ☐ DOCTOR REFERRAL: _____
☐ KELLER CHAMBER ☐ NORTHEAST TARRANT CHAMBER ☐ NEIGHBORHOOD GROUP/PAGE
☐ OTHER: _____

PLEASE PRESENT YOUR INSURANCE CARD(S) AND DRIVERS LICENSE TO RECEPTIONIST

PRIMARY INSURANCE POLICY HOLDER

POLICY HOLDER'S NAME:	POLICY HOLDER'S SSN:	POLICY HOLDER'S DOB:	RELATIONSHIP TO PATIENT:	
INSURANCE NAME:	INSURANCE ID:	GROUP #:		
ADDRESS:	CITY:	STATE:	ZIP:	PHONE:

SECONDARY INSURANCE POLICY HOLDER (if applicable)

POLICY HOLDER'S NAME:	POLICY HOLDER'S SSN:	POLICY HOLDER'S DOB:	RELATIONSHIP TO PATIENT:
INSURANCE NAME:	INSURANCE ID:	GROUP #:	

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