

Medi Urgent Care Center

111 Carter Park Drive

Seneca, SC 29678

Patient's Name: (Last) _____ (First) _____ (MI) _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone # (____) _____ Work Phone # (____) _____

Cell # (____) _____ SS# _____

D.O.B.: _____ Age: _____ Sex: _____ Marital Status: (Circle one) S M W D

Spouse's / Parent's Name: (Last) _____ (First) _____ (MI) _____

Spouse's / Parent's SS# _____ Spouse/ Parent's D.O.B _____

PRIMARY INSURANCE

Insured's Name _____ Insured's D.O.B _____

Insurance Name and Address: _____

City: _____ State: _____ Zip _____

Insured SSN / ID # _____ Insured's Group # _____

SECONDARY INSURANCE

Insured's Name _____ Insured's D.O.B _____

Insurance Name and Address: _____

City: _____ State: _____ Zip _____

Insured SSN / ID # _____ Insured's Group # _____

Is this Workman's Comp? _____ Is an attorney involved? _____

Referred By: _____ Phone # (____) _____

Primary Care Physician: _____ Phone # (____) _____

Emergency Contact Person: _____ Phone # (____) _____

Assignment of Benefits: I hereby authorize direct surgical/medical benefits to Medi Urgent Care Center or its Physician for services rendered by them or under their supervision. I understand that I am financially responsible for any co-pays, deductibles, or co-insurance, not covered by my insurance. I hereby authorize Medi Urgent Care Center and staff members to release any medical or incidental information that may be necessary for other medical care or in processing applications for financial benefits.

Patient / Guarantor: _____ Date: _____