Date: _____ Time: _____

PATIENT NAME: _____DATE OF BIRTH:_____AGE_____

GENDER: FEMALE/ MALE PHONE NUMBER:_____ OTHER NUMBER:_____

MAILING ADDRESS: (#/ Street)_____

CITY_____STATE_____ZIP_____

INSURANCE HEALTH PLAN NAME:_____ HMO/ PPO

MEMBER ID#_____ PRIMARY CARE PHYSICIAN:_____

PHARMACY:_____STREET_____ CITY_____ ZIP_____

REASON FOR TODAY'S VISIT:_____

PATIENT EMAIL:_____

IS THIS AN ILLNESS OR INJURY ☐ ILLNESS ☐ INJURY / IS THIS A WORK RELATED INJURY ☐ YES ☐ NO

**_____ I understand that all costs are an estimation and are not a guaranteed price.**
**_____ I understand that any payments are due at the time of service.**
**_____ I understand that the DOHC Immediate Care is not an urgent care and the services rendered will be billed as an office visit from an office location.**

Date: _____ Time: _____

PATIENT NAME: _____DATE OF BIRTH:_____AGE_____

GENDER: FEMALE/ MALE PHONE NUMBER:_____ OTHER NUMBER:_____

MAILING ADDRESS: (#/ Street)_____

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INSURANCE HEALTH PLAN NAME:_____ HMO/ PPO

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