Urgent Care Center of South Bay

4305 Torrance Blvd., Suite #106, Torrance, CA 90503
Phone Number 310-542-9758 Fax 310-542-9292
Email: UrgentCenterofSouthBay@gmail.com

PATIENT DEMOGRAPHIC FORM

Patient Information **(PLEASE PRINT CLEARLY)**

Last Name: _____ First Name: _____
Social Security#: ____-____-____ Date Of Birth: ____-____-____ Sex: M____ F____
Address: _____ Apt: _____
City: _____ State: _____ Zip Code: _____
Home Phone: (____)_____ Work Phone: (____)_____
Cell Phone: (____)_____ **Email Address:** _____@_____
Race: _____ Language: _____ Ethnicity: _____
Marital Status: S____M____D____W____ Employer: _____
Emergency Contact: _____ Relationship: _____
Emergency Contact Phone # (____)_____
How did you hear about us? **(please circle)** Website Yelp ZocDoc Google Word of Mouth Drive By Other_____

Guarantor / Policy Holder Information

Last Name: _____ First Name: _____
Social Security#: ____-____-____ Date Of Birth: ____-____-____ Sex: M____ F____
Address: _____ Apt: _____
City: _____ State: _____ Zip Code: _____
Home Phone: (____)_____ Work Phone: (____)_____
Cell Phone: (____)_____ Email Address: _____@_____
Race: _____ Language: _____ Ethnicity: _____
Marital Status: S____M____D____W____ Employer: _____
Relationship: _____

Primary Care Physician and Pharmacy Information

Primary Care Physician: _____
Phone Number: (____)_____ Fax Number: (____)_____
Address: _____ Suite: _____
City: _____ State: _____ Zip Code: _____

Pharmacy Name: _____
Address: _____ City: _____
State: _____ Zip Code: _____ Phone # (____)_____ Fax # (____)_____

I hereby authorize my insurance benefits to be paid directly to Urgent Care Center of South Bay. I understand and am responsible for all charges including my added costs incurred due to an effort to collect for services rendered. I realize I am responsible to pay for non- covered services and I hereby authorize the release of pertinent medical information to insurance company.

Signature of Responsible Party: _____ Date: _____

Referred By: _____

Please read and sign the following agreement so that we may proceed with your care and treatment at Urgent Care Center Of South Bay

CONSENT TO MEDICAL CARE: The undersigned hereby consents to the procedure that may be performed today as well as in the future during outpatient treatment, including emergency services, or other services rendered under general and special instructions of my physician.

FINANCIAL AGREEMENT: The undersigned, whether signed as a patient or representative of the patient, agrees to pay all charges for medical services not otherwise covered by health care benefits, in accordance with the rates of the Urgent Care Center of South bay. If the account is referred to an attorney or collection agency, the undersigned agrees to pay actual collection costs, including attorney's fee, together with interest at the legal rate.

ASSIGNMENT OF BENEFITS: the undersigned, whether signed as a patient or representative of the patient, authorizes direct payment to the Urgent Care Center of South Bay of any health care coverage benefits otherwise payable to or on behalf of the patient for medical services rendered to us, including any emergency services, if any. Health care coverage benefits include Medicare, PPO, EPO, POS, HMO, other government issued health care benefits, as well as coverage under Workers' Compensation, automobile, life/ accident, and disability insurance plans. The undersigned authorizes release of medical information necessary to determine the eligibility and benefits payable and to submit and process claims for payment.

WAIVER OF OUTSIDE LABORATORY AND RADIOLOGIST : The undersigned, whether signed as a patient or representative of the patient understands that Urgent Care Center Of South Bay may send lab specimens to an outside laboratory or send x- rays taken by the Urgent Care Center Of South Bay to an outside Radiologist for over – reading. The undersigned, whether the patient or the representative of the patient, authorizes us to bill the insurance for any services. . The undersigned whether the patient or the representative of the patient, understands that they may incur additional charges as a result and understands that Urgent Care Center Of South Bay is not responsible for payment to those laboratories and radiologist.

RELEASE OF MEDICAL INFORMATION: The undersigned, whether the patient or the representative of the patient, authorizes Urgent Care Center Of South Bay to release the medical records covering my son/ daughter/ self to any physician, hospital, or agency involved in the care of the patient listed.

WAIVER OF ON SITE PRESCRIPTION PROGRAM (OPTIONAL): . The undersigned, whether the patient or the representative of the patient, has an option to have your prescription purchased from Urgent Care Center Of South Bay. We do not participate in prescription insurance program and will not refund any prescription for any reason.

NOTICE TO CONSUMERS: Medical doctors are licensed and regulated by the Medical Board of California 1 (800) 633-2322 www.mbc.ca.gov

THE UNDERSIGNED CERTIFIES THAT HE OR SHE HAS READ AND UNDERSTANDS THIS FORM, AND ACCEPTS AND AGRESS TO ABIDE BY ITS TERMS.

SIGNATURE of Patient/ Parent/ Conservator/ Guardian/ Agent:

_____

Date_____

FINANCIAL RESPONSIBILITY AGREEMENT BY PERSON OTHER THAN PATIENT OR THE PATIENTS' LEGAL REPRESENTATIVE:

SIGNATURE (Financial Responsible party) : _____

Relationship:_____

Date:_____