CONFIDENTIAL PATIENT INFORMATION
KERRIGAN FAMILY MEDICAL GROUP/HEALTHCARE EXPRESS URGENT CARE

PATIENT INFORMATION

Name ______________________________ ______________________________

Address ______________________ City ________________ State ________ Zip ________

Home Phone: ________________ Cell Phone ________________ Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Date of Birth ________________ ________________ Social Security# ________________

Are you currently: ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled Primary Language ☐ English ☐ Spanish ☐ Other ________

If Employed, please complete the information below: (If a Teacher Identify School Name and District)

Employer Name ______________________________ Phone Number ________________

Address ______________________ City ________________ State ________ Zip ________

______________________________ ________________

INSURED PARENT/GUARDIAN INFORMATION

Name ______________________________ Relationship ________________

Address ______________________ City ________________ State ________ Zip ________

Home Phone ________________ Cell Phone ________________ Sex ☐ Male ☐ Female

Date of Birth ________________ ________________ Social Security# ________________

If Employed, please complete the information below

Employer Name ______________________________ Phone Number ________________

Address ______________________ City: ________________ State ________ Zip ________

PRIMARY INSURANCE INFORMATION

Name ______________________________

Address ______________________________

City ________________ State/Zip ________________

Phone# ______________________________

Insured's Name ______________________________

ID# Group#

SECONDARY INSURANCE INFORMATION

Name ______________________________

Address ______________________________

City ________________ State/Zip ________________

Phone# ______________________________

Insured's Name ______________________________

ID # Group#

EMERGENCY CONTACT

Name ______________________________ Relationship ________________

Address ______________________ City ________________ State ________ Zip ________

Phone ______________________________

AUTHORIZATION FOR TREATMENT MEDICAL AND/OR SURGICAL

I hereby authorize treatment, medical and or/surgical of above named person. I consent to laboratory procedures, physical therapy, or medical surgical treatment, deemed necessary by my physician.

RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS

I hereby authorize and request my insurance company to pay any and all medical benefits directly to Kerrigan Family Medical Group/Healthcare Express Urgent Care. I understand that I am financially responsible for any charges not paid by my insurance carrier and hereby authorize Kerrigan Family Medical Group/Healthcare Express Urgent Care to release any information necessary to process my claim.

Patient or Guardian's Signature: ______________________________ **Date** ________________