_____ SignatureCare EMERGENCY CENTER

PLEASE PRINT LEGIBLY

PATIENT INFORMATION

FIRST NAME: _____ **LAST NAME:** _____ **MI:**____ **DOB:** _____ **MARITAL STATUS:**_____

ADDRESS:_____ **APT#**____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

HOME PHONE:_____ **CELL PHONE:** _____ **WORK PHONE:**_____

EMAIL: _____ **Sex: F ☐ M ☐** **SOCIAL SECURITY #:** _____

RACE: _____ **☐ Hispanic** **☐ Not Hispanic**

GUARANTOR INFORMATION (PERSON FINANCIALLY RESPONSIBLE)

☐ **SAME AS PATIENT**

FIRST NAME: _____ **LAST NAME:** _____

ADDRESS (IF DIFFERENT FROM PT):_____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

HOME PHONE:_____ **CELL PHONE:** _____ **WORK PHONE:**_____

SOCIAL SECURITY #_____ **RELATIONSHIP TO PATIENT**_____ **DOB:** _____

PRIMARY INSURANCE

☐ **SAME AS PATIENT**

INSURANCE COMPANY NAME: _____ **POLICY/MEMBER ID #** _____ **GROUP #** _____

SUBSCRIBER'S NAME: _____ **DOB:** _____ **RELATIONSHIP TO PATIENT:** _____

ADDRESS:_____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

HOME PHONE:_____ **CELL PHONE:** _____ **SOCIAL SECURITY #**_____

SECONDARY INSURANCE (IF NO SECONDARY INSURANCE SKIP SECTION)

INSURANCE COMPANY NAME: _____ **POLICY/MEMBER ID #** _____ **GROUP #** _____

SUBSCRIBER'S NAME: _____ **DOB:** _____ **RELATIONSHIP TO PATIENT:** _____

ADDRESS:_____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

HOME PHONE:_____ **CELL PHONE:** _____ **SOCIAL SECURITY #**_____

EMERGENCY CONTACT INFORMATION

RELATIONSHIP TO PATIENT: _____ **NAME:** _____ **CONTACT NUMBER:**_____

PATIENT/PERSONAL REPRESENTATIVE SIGNATURE: **DATE:**

PLEASE COMPLETE BOTH FORMS

Attachment B