Garrisonville Urgent Care, P.C.
Tax ID: 54-2051917

9 Center Street, Ste.101
Stafford, VA 22554
Tel: 540-288-2222
Fax: 540-288-1155

NEW PATIENT INFORMATION

PATIENT INFO

(Last)_____(MI)_____(First)_____
Date Of Birth _____ Age _____ Sex M☐ F☐ Marital Status S☐ M☐ W☐ D☐
Address: (Street)_____
(City, State, ZIP)_____
Phone #: _____ Social Security #: _____-____-_____ CELL # _____-_____-_____
If Student School Name: _____ Full/Part Time: _____
Emergency Contact Name:_____ Phone #: _____

RESPONSIBLE PARTY

Name: _____ Relationship to Patient: _____
Address: (Street) _____
(City, State, ZIP) _____
Phone #: _____ Social Security #: _____-____-_____
Work #: _____ Employer: _____

INSURANCE INFORMATION

Insurance Co: _____
Group #: _____Certificate or ID #: _____
Insured's Name: _____ Relationship to Patient:_____
Insured's Employer: _____ Employer Phone #:_____
*** Insured's Social Security** #:_____-_____-_____ ***Date Of Birth**: _____ Sex ☐M ☐F

If the patient is covered by another insurance policy, please complete the following information for coordination of benefits. This information will enable your insurance company to process your claim more quickly. Thank you!

SECONDARY INSURANCE INFORMATION

Insurance Co: _____
Group #: _____Certificate or ID #: _____
Insured's Name: _____ Relationship to Patient:_____
Insured's Employer: _____ Phone #: _____
Insured's Social Security #:_____-_____-_____ Date Of Birth: _____ Sex ☐M ☐F

I hereby assign, transfer, and set over to Garrisonville Urgent Care all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I further agree in the event of non-payment, to bear the costs of collection,and/or Court costs and reasonable legal fees should be required.

Parents/Patients Signature _____ Date _____