



**MINOR CARE PATIENT CHECK-IN FORM**

*Please print clearly.*

<b>TODAY'S VISIT INFO</b>
<b>Reason for Visit/Symptoms:</b>
<i>Has the Patient been treated for above recently? [ ]No [ ]Yes when _____</i>
<i>Is this work related? [ ]Yes [ ]No Is this from a motor vehicle accident (car, motorcycle, ATV)? [ ]Yes [ ]No</i>

<b>PATIENT INFORMATION</b>		
<b>Last Name:</b>	<b>First Name:</b>	<b>MI:</b>
<b>Social Security #:</b>	<b>Date of Birth:</b>	<b>Sex: [ ]M [ ]F</b>
<b>Physical Address:</b>		
<b>City:</b>	<b>State:</b>	<b>Zip:</b>
<b>Telephone # Home:</b>	<b>Cell:</b>	<b>Other:</b>
<b>Mailing Address (if different from physical):</b>		
<b>City:</b>	<b>State:</b>	<b>Zip:</b>
<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Widowed
<b>Email Address:</b>		
<b>Employer Name:</b>	<b>Work #</b>	
<b>Employer Address:</b>		

<b>EMERGENCY CONTACT INFORMATION</b>	
<b>Name:</b>	<b>Relation to Patient:</b>
<b>Address:</b>	<b>Telephone #</b>

<b>PARENT/GUARDIAN INFORMATION (if patient is under 18)</b>	
<b>Name:</b>	
<b>Date of Birth:</b>	<b>Social Security #:</b>
<b>Employer:</b>	<b>Work #:</b>
<b>Employer Address:</b>	

<b>PRIMARY INSURANCE COMPANY INFO</b>	<b>SECONDARY INSURANCE COMPANY INFO (if applicable)</b>
<b>Policy Holder:</b>	<b>Policy Holder :</b>
<b>Date of Birth:</b>	<b>Date of Birth:</b>
<b>Social Security #:</b>	<b>Social Security #:</b>
<b>Relation to Patient:</b>	<b>Relation to Patient:</b>

*I understand this is not a physician's office and I may be billed at an outpatient hospital rate. I also understand that I will be seen by a mid -level provider (Physician Assistant or Nurse Practitioner).*

\_\_\_\_\_ *Initial*

*If my treatment today requires lab work to be sent out for further testing, I understand that I may be billed for additional charges.*

\_\_\_\_\_ *Initial*

*I acknowledge that the above information is correct and current to the best of my knowledge.*

\_\_\_\_\_ Signature

\_\_\_\_\_ Relationship