



Adult

# WELCOME

Thank you for choosing ASAP Minor Medical.

Patient Information			
Patient Name: <small>Last</small> _____ <small>First</small> _____ <small>MI</small> _____		Birth Date: _____	Age: _____ Sex: <b>M / F</b>
Other Name: <small>(Maiden/Legal/Previous)</small> _____		Status: Single / Married / Divorced / Separated / Widow	
Address: <small>Street</small> _____ <small>City</small> _____ <small>State</small> _____ <small>Zip</small> _____			
Phone Numbers: Home _____ Cell _____ Work _____			
E-mail: _____			
Employer: _____			
Primary Language: _____		Ethnicity: <small>(Circle One)</small> Hispanic/Latino / Not Hispanic/Latino / Declined / Unknown	
Race: <small>(Circle One)</small> American Indian/Alaska Native -- Asian -- African American -- Native Hawaiian/Pacific Islander -- White -- Other Race -- Unknown -- Declined			
Referring Physician: _____		Clinic Name: _____	
<small>Pharmacy Name</small> _____ <small>Street</small> _____ <small>City</small> _____ <small>State</small> _____ <small>Zip</small> _____ <small>Phone Number</small> _____			
Preferred Pharmacy: <input type="radio"/> Please check to authorize ASAP Minor Medical to exchange electronic communications with your pharmacy.			
Emergency Contact: _____		Relationship: _____	
Primary Phone: _____		Work Phone: _____	
<b>Primary Insurance</b> - Insurance companies require this information for billing purposes. Please give copy of card to Registration.			
Insurance Company: _____		Policy #: _____	Group #: _____
		<small>(MM/DD/YYYY)</small>	<small>(MM/DD/YYYY)</small>
Name of Policy Holder: _____		Policy Holder Date of Birth: _____	Coverage Effective Date: _____
<b>Secondary Insurance</b> - Insurance companies require this information for billing purposes. Please give copy of card to Registration.			
Insurance Company: _____		Policy #: _____	Group #: _____
		<small>(MM/DD/YYYY)</small>	<small>(MM/DD/YYYY)</small>
Name of Policy Holder: _____		Policy Holder Date of Birth: _____	Coverage Effective Date: _____
<b>Workers' Compensation or Accidental Injury Information</b>			
Type of Claim: <small>(Circle One)</small> Workers' Compensation / Auto / Other: _____			
Name of Insurance: _____		Address of Insurance: <small>Street</small> _____ <small>City</small> _____ <small>State</small> _____ <small>Zip</small> _____	
		<small>(MM/DD/YYYY)</small>	
Claim Number: _____		Date of Injury: _____	Employer at time of injury: _____
Contact Person and Phone Number: _____		Attorney Name and Phone Number: _____	
<b>Signature</b>			

I agree to accept financial responsibility for charges not covered (or denied) by my third party or Workers' Compensation insurance.

Signature \_\_\_\_\_

Date \_\_\_\_\_