Elizabeth Lake Urgent Care
2446 Elizabeth Lake Road,
Waterford Twp, MI 48328

Patient Information

PATIENT INFORMATION E-Mail Address:____

Name:____
(First) (Middle) (Last)

Address:____
(Street Address) (City) (State) (Zip Code)

Home phone: (_____)______________ Work phone: (_____)______________ Cell Phone: (_____)_____________

Employer Name / Address:____ Occupation:__________________

Primary Language __________________ Ethnicity ____________________

Gender: Male Female Date of Birth:_____________ Age: ________ SS#________________

Single Married Widowed Separated Divorced

EMERGENCY CONTACT____
(Name)

______________________________________(_____)__________________________
Relationship to patient phone number

Reason for Visit:____

How did you hear about us?

Previous Patient	Word of Mouth	Facility Signage
Internet Search	Print Advertising	Phone Book/Yellow Pages
Employer: ____________________	School/Daycare: ______________________	
Physician Referral: ____________________	Pharmacy: __________________	Other

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PRIMARY CARE PHYSICIAN

Name:___________________________________ Phone: (_____)___________________________

PHARMACY (OPTIONAL)

Name:___________________________________ Phone: (_____)___________________________

PRIMARY INSURANCE INFORMATION (Fill out this portion ONLY if card is not present)

Insurance Company:____

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Type: HMO/PPO Medicare Medicaid/AHCCCS Tricare Other ____________________________

ID / Policy #________________________________ Group #:_______________________________

Copay Amount:_________________ Effective Date:___________________

Secondary Insurance? Yes No Name:____

Guarantor for Minor: Authorization to Treat Minor

Full Name:____ Date of Birth:________________

Social Security #:____________________ Relationship to Patient:_________________

Permanent Address:____
(Street) (City) (State) (Zip)

Primary Phone #:____________________________ Secondary Phone #:_____________________________

Parent or Legal Guardian Signature:____

Consent for Treatment:

I consent to the performance of all routine medical care and treatment (e.g. tests, therapy, medical treatment or procedures, etc.) which may be performed as deemed necessary by and under the general and special instructions of the physician and/or authorized health care providers of Elizabeth Lake Urgent Care.

Release of Information

I agree that, to the extent necessary to determine liability for payment and to obtain reimbursement, or as otherwise permitted or required by law, Elizabeth Lake Urgent Care may disclose any portion of my/the patient's medical records including but not limited to, information about my/the patient's diagnosis and/or treatment relating to medical, mental health, developmental disability, and/or substance abuse treatment to any person, regulatory or government agency, or corporation including, but not limited to, insurance companies, or health care service plans which are, or may be liable for, all or any portion of Elizabeth Lake Urgent Care's charges. To ensure coordination of my/the patient's ongoing care and treatment, I also consent to the release of any medical information to y/the patient's primary care physician or health care provider and any consulting physicians or health care providers participating in my/the patient's care.

Privacy Notice: HIPAA

By signing this section, you acknowledge receipt of Notice of Privacy Practices of Elizabeth Lake Urgent Care.
By signing this section, you also agree to the two paragraphs above which explain how we may use or disclose your protected health information. We encourage you to read it in full.

Printed Name of Patient / Guardian ____

Signature ____ **Date:**____________________________

Authorization:

The undersigned certifies that the patient has read the information noted above and has been given the opportunity to have any questions answered fully and to his/her satisfaction, and has the option to receive a copy of this agreement upon request. The undersigned further certifies that the patient is 1) the patient or 2) the patient's legal representative or 3) is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

Signature of Patient (or Guardian):____ **Date:**___________