

Fast^{ER}care

PATIENT INFORMATION Sex: M [] F [] Marital Status: Married [] Single []

DOB: _____ SSN: _____

Last Name: _____ First Name: _____ M.I. _____

Address: _____ Apt: _____ City: _____

State: _____ Zip Code: _____ Home Phone: () _____ - _____

Cell Phone: () _____ - _____ Work Phone: () _____ - _____

POLICY HOLDER Sex: M [] F [] Marital Status: Married [] Single []

DOB: _____ SSN: _____ Relationship to Patient: _____

Policyholder's Last Name: _____ First Name: _____ M.I. _____

Address: _____ Apt: _____ City: _____

State: _____ Zip Code: _____

Home Phone: () _____ - _____ Cell Phone: () _____ - _____

Employer: _____ Work Phone: () _____ - _____

Primary Insurance: _____ Policy ID: _____ Group #: _____

EMERGENCY CONTACT

I hereby give consent to the release of information concerning my medical condition & treatment to the following person. I have reviewed the **Notice of Privacy Practices** and understand I may receive a printed copy of this information upon verbal or written request now or at anytime in the future.

Last name: _____ First Name: _____

Relationship to Patient: _____ Phone: () _____ - _____

Address: _____ Apt: _____ City: _____

State: _____ Zip Code: _____