Abington Health
Urgent Care Center

Patient Demographics Form

Today's Date:		
Name (Last, First):	Gender: M F TG	
Date of Birth:	SSN:	
Street Address:		
City:	State:	Zip:
Primary Phone:		**Circle One:** Cell – Home – Work – Other **May we leave a voicemail?** YES - NO
Email:		**I would like electronic access to my records:** YES - NO
Emergency Contact Name & Number:		

Race: Asian – African American – American Indian or Alaskan Native – Caucasian – Pacific Islander - Other

Ethnicity: Latino - Non-Latino

Preferred Language: English – Indian – Russian – Spanish - Other

Primary Physician/PCP Name & Number:
Pharmacy Name & Location:
Pharmacy Phone/Fax:

REASON FOR VISIT (What's bothering you today?)…

_____

Have you traveled to Africa in the last 30 days or had contact with anyone who has traveled to Africa and may be sick? Please respond below:

☐ **No** ☐ **Yes (Please explain)**_____

How did you hear about us?

- □ Billboard
- □ Outside Signage/Flags
- □ Newspaper Advertisement
- □ Magazine Advertisement
- □ Clipper Magazine/Coupon
- □ Digital Ad online
- □ Google search for Urgent Care
- □ Mailing to Home
- □ Radio Advertisement
- □ Abington E-newsletter
- □ Social Media (Twitter/Facebook/YouTube)
- □ Family or Friend
- □ Primary Care Physician
- □ Specialist Physician
- □ Community Event
- □ Medical Insurance Company
- □ Previous Patient
- □ Abington Health Employee
- □ Abington Urgent Care Website
- □ Yellow Pages
- □ *Touching Your Life* Magazine

Abington Health Physicians

Please sign below. This is required for your benefits to be paid directly to the practice.

REQUEST FOR PAYMENT AND ASSIGNMENT OF BENEFITS

I request payment and authorize any healthcare benefits that are otherwise payable to me by any insurance provider, benefit plan or other third party payer, under the terms of the insurance policy or benefit plan be paid directly to Abington Health Physicians (AHP). I understand that:

* I may be responsible for payment in full of any amount due that is not covered or paid for by any insurance policy or benefit plan.
* If my account is referred to an attorney or agency for collection of any unpaid balances for which I am responsible, that I will also be responsible for reasonable attorney's fees and collection expenses.
* My obligation to pay may not be deferred for any reason, including pending legal actions against other parties to recover medical costs.

RELEASE OF INFORMATION

I authorize AHP and/or their agents:

* To give the insurance provider, benefit plan, or other third party payer, or their agents, any medical or other information necessary to receive payment or obtain authorization for services, supplies and equipment.
* To request and receive directly, on my behalf, any information related to my insurance policy or benefit plan (including, but not limited to, proof of my healthcare benefits).
* To file, on behalf of themselves or on my behalf, claims for benefits and/or appeals of any denied claims or authorization and to take action in my name against any insurance company, benefit plan or other third party payer, to receive any benefits that may be due or payable under the insurance policy or benefit plan.
* To give medical or other information to any healthcare practitioner providing healthcare services to me or receive information from them.

STATEMENT OF ASSISTANCE

I agree::

* To assist AHP in collecting benefits that may be due or payable under my insurance policy or benefit plan for the services, supplies and equipment provided.
* To provide any additional information needed to process the claim for payment.
* That a photocopy or other reproduction of this document shall be considered as valid as the original.

_____ _____ _____

Signature of Patient / Signature of Person Authorized to Consent for Patient ***Relationship to Patient*** ***Date***

_____ _____

Signature of Witness ***Date***

_____

If the patient is unable to sign upon arrival, state the reason and initial

I certify that the information on this form is correct and current:

Date: _____ **Signature:** _____

Date: _____ **Signature:** _____

Date: _____ **Signature:** _____

For office use only:

Authorization Number_____ Dates _____

Review necessary? _____

Form should be completed at patient's first visit, whenever changes are indicated or at least annually per policy.

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