Thousand Oaks
URGENT CARE

PATIENT INFORMATION

Name: _____ Date of Birth: _____
Last First Middle Initial

Social Security #: _____ Gender: Male ☐ Female ☐

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell Phone #: _____

E-Mail Address: _____

Employer Name: _____ Phone #: _____

Emergency Contact Name: _____ Phone #: _____

IF SOMEONE OTHER THAN PATIENT IS RESPONSIBLE FOR PAYMENT, PLEASE COMPLETE:

Name: _____ Date of Birth: _____
Last First Middle Initial

Social Security #: _____ Home Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Relationship to Patient: _____

INSURANCE LIABILITY

Our facility is contracted with most insurance carriers and bills all insurance carriers as a courtesy to our patients. However, payment for all services rendered is ultimately the patient's responsibility.

PRIMARY INSURANCE INFORMATION

Insurance Company: _____ Policy #: _____

Insurance Subscriber: _____ Subscriber Date of Birth: _____

Subscriber Social Security #: _____ Relationship to Patient: _____

SECONDARY INSURANCE INFORMATION

Insurance Company: _____ Policy #: _____

Insurance Subscriber: _____ Subscriber Date of Birth: _____

Subscriber Social Security #: _____ Relationship to Patient: _____

It is understood and agreed that I, the patient and/or responsible party acknowledge and accept full responsibility of charges for the services rendered at **Thousand Oaks Urgent Care**. I also authorize the release of any medical information necessary to process this claim. I authorize payment of medical benefits to the physician or supplier of services rendered. I also understand that I am responsible for all the co-pays, deductibles, non-covered services and claims denied, including but not limited to, medical necessity.

Thousand Oaks Urgent Care is committed to providing the highest quality care to all our patients. Please let us know if you have any questions or concerns.

Patient/Guardian Signature: _____ Date: _____