Nebraska Urgent Care Center

Date:	Primary Care Physician:		Pharmacy:
Patient Name:		Social Security #:	
Address:			
Street	City	State	Zip
Telephone #:	Date of Birth:	Age:	
Work Telephone #:	Marital Status: Married Single Widowed Divorced		
Employer:	Job Title:		
Email address :			
Responsible Party (person responsible for bill) if different from patient please fill this portion out			
Name:		Social Security #:	
Address:			
Street	City	State	Zip
Telephone #:	Relationship:	Self Parent Spouse Other	
Work Telephone #:	Date of Birth: (if different from patient)		
Primary Insurance Company			
Subscriber Name:	Subscriber DOB:		
Subscriber Address:	Subscriber Phone #		
Subscriber Social Security #:	Subscriber's Employer:		
Insurance Policy #:	Insurance Group #:		
Secondary Insurance Company			
Subscriber Name:	Subscriber DOB:		
Subscriber Address:	Subscriber Phone #:		
Subscriber Social Security #:	Subscriber's Employer:		
Insurance Policy #:	Insurance Group #:		
Emergency Contact-A person not residing with you			
Name:	Relationship:		
Address:			
Contact's Telephone #	Home:	Work:	
Payment is expected at the time services are rendered			
Please read carefully before signing			

I hereby authorize Nebraska Urgent Care Center LLC to release information acquired during the course of my examination and treatment to Centers for Medicare/Medicaid Services (CMS) and its agents, Medigap or any other third party carrier, as necessary, to secure payment of any benefits due. I hereby assign payment of said benefits to include Medicare and Medigap directly to Nebraska Urgent Care Center LLC for any medical procedures performed. I understand that I am responsible for all charges regardless of insurance status as well as any associated cost for collection should such action become necessary. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date. A photocopy of this assignment shall be considered as valid as the original. I have read the above and fully understand the terms thereof.

Signature:_____

Patient signature (or parent, if patient is under 19) Date

Nebraska Urgent Care Center

Name:_____ **DOB**_____

Reason for your visit today:

_____

Substance use history:

Tobacco use, smoke, vape, chew: Yes/NO
If yes, how many packs per day? _____

Alcohol Use: YES/NO
If alcohol use, how many drinks per week? _____

Illegal Drug Use (past or present)? YES/NO

Allergies:

_____

_____

_____

_____

Medications:

_____ _____

_____ _____

_____ _____

_____ _____

Prior surgeries:

_____

_____

_____

_____

Health History: (ex: hypertension, thyroid issues etc ;)

_____ _____

_____ _____

_____ _____

_____ _____

Immunizations up to date?:
(Circle one)
YES NO

Family Health History:

_____ _____

_____ _____

_____ _____

_____ _____