Urgent Care & Family Practice Center
405 North Clyde Morris Blvd Daytona Beach, FL 32114

Patient information

How did you hear about us? ☐ Website ☐ Friends/Family ☐ Phonebook ☐ Other

Last Name:…… First Name:…….. Middle Initial:……

Age:……. DOB:…….. Sex: M F SS#:…… Name Suffix:……..

Marital Status:…… Employment Status:……. Email:……

Preferred Language:…….. Race:…… Ethnicity:……

Permanent Address:……

City:…….. State:…… Zip:…… Occupation:……

Home Phone:…… Work:…… EXT:…… Cell:……..

Temporary Address:……

City:……. State:…… Zip:……..

Emergency contact:…… Phone#:…… Relationship:……..

Address:…… City:……. State:…….. Zip:……..

Employer:…… Phone#: ……. EXT:……..

Employer's Address:…… Years with employer:……

If Proper insurance information is not provided on the date of service, our office is not responsible filing back charges. Please be advised that it is **your responsibility** to be aware of the benefits that your medical plan provides.

PRIMARY INSURANCE COMPANY

Company: ……

Policy:……

Group#:……

Policy Holder:……

Policy Holder DOB:……

Phone#:……

SECONDARY INSURANCE COMPANY

Company:……

Policy:……

Group#:……

Policy Holder:……

Policy Holder DOB……

Phone#:……

****Please indicate the lab your insurance co. Quest…… Lab One……. LabCorp…… Other Labs…… I understand that if my choice for *LAB DIRECTIVE is incorrect, I am financially responsible for the bill that the lab sends me. If no lab chosen we will send to Quest Laboratory automatically. And also give consent for medical evaluation or treatment to Dr. Ejaz Ahmed MD.**

I, …… hereby assign all medical benefits, to include major medical benefits to which I am entitled including Medicare and other government sponsored programs, private insurance, and any other health plans to Dr. Ejaz Ahmed Urgent Care & Family Practice Center. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all chargers whether or not paid by my insurance. I authorize release to my insurance carder, employer, and referring physician any information needed including diagnoses and records of any treatment or examination rendered to me to process this claim. Lifetime signature authorization. This authorization and assignment are to be continuing, remaining in force until revoked in writing by the under aligned for services beginning:

Patient/Guardian Signature:…… Date:……