SINAI URGENT CARE

Patient Information

Date: _____

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

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

DOB: _____ Age: _____ ☐ Male ☐ Female SSN: _____

Race: _____ Primary Language: _____ Hispanic: Yes / No

Day-time Phone: _____ Home Phone: _____

E-Mail Address _____

Guardian information (if patient is a minor) _____

Emergency Phone: _____ Marital Status: Married / Single / Divorced / Widowed

Please List any Impairments (visual, hearing, or other): _____

Employer:_____ Occupation:_____

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

Family Physician:_____ Phone:_____

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

Insurance Information:

Insurance Carrier: _____ ID# _____ Group: _____

Policy SUBSCRIBER (Name/Relation to the patient) _____

(NOTE TO PATIENT: While we are not PARTICIPATING with ALL plans, we ACCEPT ALL commercial insurances, as well as Medicare and Tricare.)

Is this visit Work related? **☐YES ☐NO**

WC CLAIM/CASE# _____ Date of injury: _____

WC Insurance Company Name: _____Telephone: _____

Adjuster's name/contact information: _____

Is this visit related to an MVA? **☐YES ☐NO**

Policy # _____ MVA CLAIM# _____Date of injury: _____

Insurance Company name: _____ Telephone: _____

Adjuster's name/contact information: _____

FOR INTERNAL USE ONLY:

Policy effective date: _____ Policy Type: ☐PPO ☐POS ☐HMO ☐EPO **☐ In Network ☐ Out of Network**

OFFICE CO-PAY: $_____ URGENT CARE/SPECIALIST: $_____ DEDUCTIBLE: $_____ DEDUCTIBLE AMOUNT MET: $_____

CO-INSURANCE: _____% OUT OF POCKET: $_____ OUT OF POCKET AMOUNT MET: $_____

Benefits verification: ☐Availity ☐Navinet ☐Payor Portal ☐IVR (Telephone) Ref#_____

Did you print out eligibility for patient's reference? ☐YES ☐NO