EMERALD COAST
Walk-in Clinic
Urgent Care & Sports Medicine

Reason for visit: _____ Primary Care Provider: _____

PATIENT INFORMATION
Patient Name: _____ Date of Birth: ____ / ____ / ____
SSN: _____ Home phone: _____ Mobile Phone: _____
Sex at Birth: ☐ Male ☐ Female ☐ Unknown Email: _____
Street Address: _____ Apt: _____
City: _____ State: _____ Zip: _____
Preferred Language:
Race: ☐ American Indian or Alaska Native ☐ Black or African American Asian
☐ Native Hawaiian or Other Pacific Islander ☐ Caucasian
☐ Prefer not to Answer
Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino ☐ Prefer not to Answer

EMERGENCY CONTACT:
Name: _____
Relationship: _____
Home Phone: _____
Mobile Phone: _____

INSURANCE INFORMATION
Primary Insurance: _____ Subscriber ID: _____
Subscriber Name: _____ Subscriber DOB: ____ / ____ / ____
Relationship to Patient: _____
Secondary Insurance: Subscriber ID: _____
Subscriber Name: _____ Subscriber DOB: ____ / ____ / ____
Relationship to Patient: _____

PERTINENT MEDICAL HISTORY

Please list any medical problems:

Please list any current medications:

Medication	Dosage	Frequency

Please list any drug allergies:

Pertinent Surgical History:

Pharmacy: _____

AUTHORIZATIONS AND CONSENT

I authorize Emerald Coast Walk-In Clinic to contact me via voicemail, email, and text at the telephone numbers and email address provided above. I understand this could result in a charge from my phone or device carrier to me for talk time, SMS messaging/texts or data usage for emails or voice mails. I understand that voicemail, email, and text messaging are not secure formats of communication. There is some risk that individually identifiable health information or other confidential information contained in such voicemail, email, and text may be misdirected, disclosed to, or intercepted by unauthorized third parties. I may revoke or withhold my consent to use any one or more of these means of communication at any time for my health information but will maintain at least one method for DMS to contact me for billing and insurance issues.

Signature: _____ **Date:** _____

I, the undersigned, consent to the care and treatment by the attending provider, his/her associates or assistants and acknowledge that no guarantees have been made as to the effect of such treatment.

Signature: _____ **Date:** _____

I have reviewed the Notice of Privacy Practices as provided at registration and understand that I may request a copy of the policy at any time.

Signature: _____ **Date:** _____

FINANCIAL RESPONSIBULITY/ASSIGNMENT OF BENEFITS ☐ Same as patient information

Name: _____ ☐ Male ☐ Female Phone #: _____

Date of Birth: ____ / ___ / ___ SSN: _____ Relationship to Patient: _____

Except for services covered by my Medicaid coverage plan, I acknowledge full financial responsibility for any services rendered and I understand that the payment of charges incurred in this office are due at the time of service. I also understand that the charges not covered by insurance remain my responsibility and assign insurance benefits to this office. In the event my account is turned over to a collection agency, I agree to pay all costs of collection fees and/or attorney's fees and all court costs if any.

Signature: _____ **Date:** _____