ChoiceOne
URGENT CARE

Check-In Form

Patient

Date: ____/____/____ Email: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of birth: ____/____/____ Phone: (____) ____ - _____

PCP: _____ Gender: ❑ Male ❑ Female

PCP Phone: (____) ____ - _____ Preferred Pharmacy: _____

How did you hear about us? _____

Referred by another provider? ❑ Y ❑ N If yes, Provider name: _____

Reason for visit today: _____

Is this visit workers' comp related? ❑ Y ❑ N If yes, date of injury: _____

If yes, employer name: _____

Responsible Party (for children under 18)

Name: _____

Date of birth: ____/____/____

Patient relationship to responsible party: _____

Same address **and** phone as patient? ❑ Y ❑ N

(If no, please provide): _____

Primary Insured (insurance policy holder)

Name: _____

Date of birth: ____/____/____ Gender: ❑ Male ❑ Female

Patient relationship to responsible party: _____

Same address **and** phone as patient? ❑ Y ❑ N

(If no, please provide): _____

_____ _____ / /

Signature of patient or legally authorized representative | Relationship to patient/witness or translator | Date (MM/DD/YYYY)