Eastbluff Medical Walk-In & Urgent Care

PATIENT INFORMATION

2507 Eastbluff Drive
Newport Beach, CA 92660
PH 949.200.1655 F 949.200.1656

Personal Information

How did you hear about us? ________________________________ Date of Birth: ______________________ Age: ________

Last Name:____First Name: __________________________________MI:__________

Address: ____APT#_____________City:_____________________________________

State: __________ Zip Code: ________________________ Sex: Male / Female

Primary Phone: _______________________________ Cell Phone (Ages 18+ only):_________________________________

Marital Status: Single Married Divorced Widowed Separated

Employment: Employed Retired Disabled Student

Employer: _______________________________________ Work Phone: ____

Employer Address:_______________________________________City/State:_______________________________________

Pharmacy Information

Name:_____________________________ Location:______________________ Phone: ____________________________

Spouse/Guardian Information

Name:_____________________________ Date of Birth: ____________________ Social Security #:_____-_____-_____

Payment Information

Primary Insurance:________________________ ID #: _________________________Group #:__________________________

Policy Holder: ______________________________ Relationship to Patient:_______________Effective Date: _____________

Co-Pay Amount: $_____________ Deductible: $______________Referred by: _____________________________________

Secondary Insurance:_______________________ ID #: ________________________Group #:__________________________

Policy Holder: ______________________________ Relationship to Patient:_______________Effective Date: _____________

Primary Care Physician:_______________________________ Primary Care Physician Phone: ___________________________

Financially Responsible Party (circle one): Patient Spouse Parent/Guardian Other: __________________

Emergency Contact

Name: ____ Relationship to Patient: ______________________

Primary Phone:_________________________Cell / Work Phone: _________________________ext.______

I authorize payment of insurance benefits to be made directly to Eastbluff Medical Walk-in & Wellness Center for any services rendered. I understand that I am financially responsible for all charges covered or not covered by my insurance provider. I authorize the release of any necessary information to secure payment of benefits.

Signature: ____ Date: ____________________________