Grand Prairie Urgent Care & Family Medicine
Patient Information Form

Patient's Full Name: _____

Mailing Address:_____

City:_____State:_____Zip:_____

Home Number: _____Cell: _____

Sex: _____Date of Birth:_____SS#: _____

Patients Employer's Name: _____Phone #: _____

Emergency Contact: _____

Relationship: _____Phone #: _____

Primary Insurance Coverage

Insurance Company: _____

Name of Primary Insured: _____

Insured DOB: _____Insured SS#: _____

Employer: _____Relationship to patient: _____

ID#:_____Group #: _____

I authorize Grand Prairie Urgent Care and Family Medicine to release to my insurance carrier and/or their agents any information necessary to determine benefits payable for related services. I authorize the payment of medical benefits to Grand Prairie Urgent Care and Family Medicine. I understand that I am ultimately responsible for all services whether covered by insurance or not. I also authorize my physician, based on his/her discretion toaccess my chart for utilization management review.

Signature: _____Date: _____