Central Oklahoma Clinical Associates, PLLC
First Choice Urgent Care

PLEASE PRINT

Patient Information

Name: ____ Social Security No ____________________
Last First MI

Address ______________________________________ City ________________ State ______ Zip ________

Date of Birth __________________ Age__________ Sex: F M Marital Status: S M W D Race:________

Home Phone ____________________ Work Phone ____________________ Cell Phone ____________________

Employer: ________________________________ Home Email Address: ________________________________

Spouse's Name ____________________________ Employer __________________ Work Phone ______________

Insurance Information

Primary Insurance Name: ______________________________________ Card Copied: YES NO

Policy Holder's Name ________________________ DOB ____________ Social Security No ________________

Relationship to Patient_______________ Policy Holder's Employer ____________________________________

Secondary Insurance Name: ______________________________________ Card Copied: YES NO

Policy Holder's Name ________________________ DOB ____________ Social Security No ________________

Relationship to Patient_______________ Policy Holder's Employer ____________________________________

Emergency Contacts *(Other Than Spouse)*

Name ____ Relationship _________________________

Phone No. _________________________________ Work No. ___________________________

Who referred you to our office? ____

Responsible Party Statement and Payment of Benefits

I understand that I am financially responsible for all charges that are not directly paid by my insurance company. If the doctor is a participating provider on my insurance I understand that I a responsible for any co-pay, coinsurance or deductible not paid by my plan. I authorize my insurance company to pay benefits directly to **Central OK Clinical Assoc., PLLC/First Choice Urgent Care.**

Signed: ____ Date: ______________________________