

**8640 E CR 466, Suite A
THE VILLAGES, FL 32162**

PH (352)674-9218
Fax (352)259-6069



**628 Cagan View Road
CLERMONT, FL 34714**

PH (352)242-1988
Fax (352)242-0866

Today's Date:		Pharmacy:		PCP:	
PATIENT INFORMATION SHEET					
Patient's last name:		First:		Middle Initial:	
D.O.B: / /	Age:	Sex:	SSN: - -	Marital Status:	
Home Telephone:			Alternate Telephone:		
Mailing address:			Apt / Lot #:		
City:		State:		Zip:	
Reason for visit:		How did you hear about our clinic?		Email address:	
INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Who is financially responsible for the bill: (If patient is under the age of 18)		Birth date:		SSN:	
Is this the patients own insurance policy? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Please indicate name and birth date of primary insurance holder if other than patient Primary ____ / Secondary ____					
Subscriber's name:		Subscriber's S.S. no.:		D.O.B:	
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					
IN CASE OF EMERGENCY					
Name of local friend or relative		Relationship to patient		Home phone no.	Work phone no.
CONSENT TO TREAT/RECEIPT OF DOCUMENTS					
CONSENT TO TREAT: The above information is true to the best of my knowledge. Insurance policy limitations may not cover today's visit. I understand and agree that I am responsible for paying any non-covered charges, deductibles, and co-payments. I authorize Paramount Urgent Care or insurance company to release any information required to process my claims or to release any medical records to additional Providers as required. Additionally, I have read and understand my Health Information Patient Privacy Rights. RECEIPT OF DOCUMENTS: BY SIGNING BELOW I ALSO ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE OFFICE FINANCIAL POLICY AND THE HIPPA PRIVACY STATEMENT.					
Patient/Guardian (if patient is under 18) signature				Date:	
X					