OnSite Care Clinics
215 South State Suite 110
Salt Lake City, UT 84111
801-441-1002

Patient Information Form

Please print all information in the spaces provided. Be sure to complete and sign the statement.

Last Name ____________________ Maiden Name ______________ First Name _______________________________ MI _____

Home Address ______________________________________ City ______________________ State __________ Zip __________

Home Phone _______________________ Cell Phone ______________________ Work Phone ___________________________

Date of Birth _____________________________ Sex ____________ Marital Status _________________

Employer Name ____ Email Address ____

Pharmacy Name ___________________________ Address __________________________ City __________ Phone ___________

Responsible Party **Self**

Name ____ Relationship ________________ Date of Birth ________________

Social Security Number __________________________ Phone ____________________

Emergency Contact Information

Person to contact in the case of an emergency

Name ____ Relationship ______________________ Phone #__________________

Primary Insurance

Insurance Name & Phone Number ____

ID Number ____ Group Number____

Name of Insured ____ Relationship to Patient _________________

Address of Insured ____

Date of Birth of Insured ____

Secondary Insurance

Insurance Name & Phone Number ____

ID Number ____ Group Number____

Name of Insured ____ Relationship to Patient _________________

Address of Insured ____

Date of Birth of Insured ____

I accept responsibility for all services received by myself and all family members. I also accept responsibility for payment for any service(s) provided that is not covered by my insurance. I agree to pay all co-payments, coinsurance and deductibles as determined by my health insurance plan. I understand that there will be a $20.00 fee for any check that is not honored by my financial institution. Should collection become necessary, the responsible party agrees to pay a collection fee of 40% and all legal fees of collection, with or without suit, including attorney fees and court costs.

____ _________________________

Signature of Patient/Guardian *Date*

Your name and signature on this sheet indicates that you have received, or been offered a copy of the Joint Notice of Privacy Practices.

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Signature of Patient/Guardian *Date*