7/2020

VelocityCare
Urgent Care by CarilionClinic

PATIENT INFORMATION FORM -- CONFIDENTIAL

REASON FOR VISIT

Date _____ Time_____ Reason for Visit_____

If Injury Related, How Did it Occur?_____

Date of Injury_____ Time of Injury _____ ☐AM ☐ PM Is Injury Work Related? ☐Yes ☐No

Was Injury Caused by Someone Else or a Car Accident? ☐Yes ☐No

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PATIENT INFORMATION

Full Legal Name (Last, First, MI) _____ ☐Jr. ☐ Sr. ☐II ☐III ☐ Other _____

Preferred Name _____ SSN _____ Date of Birth _____

Legal Sex ☐Male ☐Female

Gender Identity ☐Male ☐Female ☐Transgender Male (Female-to-Male) ☐Transgender Female (Male-to-Female)
☐Other _____ ☐Choose Not to Disclose

Sex Assigned at Birth ☐Male ☐Female ☐Unknown ☐Not Recorded on Birth Certificate ☐Choose Not to Disclose

Patient Pronouns ☐She/Her/Hers ☐He/Him/His ☐They/Them/Theirs ☐Patient's Name ☐Decline to Answer
☐ Other _____

Physical Address (Required)_____ City/State/Zip_____

Mailing Address (If Different) _____ City/State/Zip_____

Preferred Phone (____) _____ ☐Home ☐Cell ☐Work ☐Other_____

Secondary Phone (____) _____ ☐Home ☐Cell ☐Work ☐Other_____

Primary Care Provider _____ ☐ M.D. ☐ N.P. ☐ P.A. Phone_____

Primary Care Provider Location_____ Fax _____

Employer _____ ☐Full ☐P/T Email _____

Preferred Language _____ ☐Interpreter Needed Religion _____

Marital Status ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed ☐Partner

Race/Physical Feature(s) ☐American Indian ☐Asian ☐African American ☐Pacific Islander ☐White
☐ Other _____ ☐ Unknown ☐Choose Not to Disclose

Ethnicity/Culture ☐Hispanic/Latino ☐Not Hispanic/Latino ☐Unknown ☐Choose Not to Disclose

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EMERGENCY CONTACTS

Primary Emergency Contact _____ Relationship to Patient _____

Primary Phone (____) _____ ☐Home ☐Cell ☐Work ☐Other_____

Secondary Phone (____) _____ ☐Home ☐Cell ☐Work ☐Other_____

Secondary Emergency Contact _____ Relationship to Patient _____

Primary Phone (____) _____ ☐Home ☐Cell ☐Work ☐Other_____

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Emergency Contact Secondary Phone (____) _____ ☐Home ☐Cell ☐Work ☐Other_____

RESPONSIBLE PARTY (GUARANTOR)

☐Same as Patient

Full Legal Name (Last, First, MI) _____ ☐Jr. ☐ Sr. ☐II ☐III ☐ Other _____

Relationship to Patient _____ SSN _____ Date of Birth _____

Legal Sex ☐Male ☐Female ☐Decline to Answer

Physical Address (Required)_____ City/State/Zip_____

Mailing Address (If Different) _____ City/State/Zip_____

Preferred Phone (____) _____ ☐Home ☐Cell ☐Work ☐Other_____

Secondary Phone (____) _____ ☐Home ☐Cell ☐Work ☐Other_____

Employer _____ ☐Full ☐P/T Email _____

INSURANCE INFORMATION

Primary Insurance Company _____

Subscriber Name _____ SSN _____ Date of Birth _____

Address (if different from above) _____

City/State/Zip_____

Subscriber Number PCP _____ Effective Date _____ Group Number _____

Group/Employer Name _____

Physical Address_____ City/State/Zip_____

Secondary Insurance Company _____

Subscriber Name _____ SSN _____ Date of Birth _____

Address (if different from above) _____ City/State/Zip_____

Subscriber Number PCP _____ Effective Date _____ Group Number _____

Group/Employer Name _____

Physical Address_____ City/State/Zip_____

COMMUNICATION PREFERENCE

Check All That Apply ☐MyChart ☐Text ☐Phone ☐Mail

☐Check here if you'd like for Carilion Clinic to provide information about our newest services, products and offerings. You may opt out at any time.

Thank you for choosing Carilion Clinic VelocityCare.