IMMEDIATE HEALTH ASSOCIATES URGENT CARE

Wedgewood Westar Newark Sunbury (Please circle sites previously visited)

Reason for today's visit: _____

PATIENT NAME: _____

Maiden Name if applicable: _____ Phone Number: _____

Date of Birth: _____ Sex assigned at birth: Female Male (circle one)

Gender Identity: _____Preferred Pronouns: _____

Address: _____ Apt/Suite/Lot# _____

City: _____ State: _____ Zip: _____

Email Address: _____ SSN _____

Marital Status: Single Married Other (circle one)

PHARMACY NAME**/**ADDRESS _____ ZIP_____

Primary Care Provider- First Name_____ Last Name_____

Address _____ Phone:_____

***Please be prepared to provide the staff a full list of current prescribed and over-the-counter medications**

Emergency Contact Information

Name _____ Relationship to patient: _____

Phone Number _____

Insurance Information

Is the patient the policy holder? YES NO (circle one)

If NO: Policy Holder's Full Name: _____ Policy Holder's date of birth _____

SECONDARY INSURANCE: _____

Policy Holder Name: _____ Date of Birth:_____

If patient is a minor

Parent/Guardian Name: _____Date of Birth: _____

Relationship_____ Phone number: _____ SSN: _____

*Written/Verbal Consent from a parent MUST be provided PRIOR to the treatment of a minor if you are not the legal parent/guardian. Minors seeking STI testing/treatment need to sign consent.

For marketing purposes, how did you hear about us? _____

Revised 9/30/24