e-mail address: _____

North Georgia Urgent Care
www.mynguc.com

DATE | NAME (Last) | First | MI

Sex: _____Male _____Female | DATE OF BIRTH | AGE | MARITAL STATUS: SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐

Street | Apt # | City | State | Zip

Permanent Street (if Different) | City | State | Zip

Social Security # | Home Phone | Cell Phone | Work Phone

Employer/School | Street Address | City | State | Zip

Referred By: ☐Ask A Nurse ☐Yellow Pages ☐Mailer ☐Magazine ☐Newspaper ☐Radio ☐Physician ☐Insurance ☐Employer ☐Employee ☐Employer ☐Other

Person responsible for bills | Relationship | Date of Birth

Street | Apt # | City | State | Zip

Social Security # | Home Phone | Cell Phone | Work Phone

Employer | Street Address | City | State | Zip

Person to Contact in an Emergency | Relationship

Home Phone | Cell Phone | Work Phone

I consent to the examination, treatment and procedures which may be performed during this visit, including emergency treatment deemed necessary by North Georgia Urgent Care staff. I understand that the examination I am about to receive should not be considered to be in lieu of my ongoing and preventative health care needs, which should be provided by my personal physician. I also authorize the release of information requested by my insurance company and the release of my medical records (current and historical) to health care providers with whom I or my treatment physician(s) may consult for medical treatment.

Signature of Patient &/or Legal Guardian or Parent _____ Date _____