1809 Northpointe Lane
Suite 102
Ruston, LA 71270
Phone: (318)255-3762
quickcareofruston.com

QuickCARE Of Ruston

Please **NOTIFY US** immediately if you have an emergency such as: Chest Pain, Head Injury, Shortness of Breath, Severe Abdominal Pain, or the Worst Headache of Your Life before continuing.

Is this visit the result of an accident? ☐Yes ☐No Did this accident occur at work? ☐Yes ☐No

Patient Last Name: _____ First Name: _____ M.Name + Suffix: _____

Sex: _____ Date of Birth: _____ SSN: _____

Home Phone: _____ Cell Phone: _____

Street Address / P.O. Box: _____ Apt. / Lot #: _____

City: _____ State: _____ Zip: _____

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

Email Address: _____

Preferred Language: _____ Race: _____ Ethnicity: _____

Preferred Pharmacy: _____

GUARANTOR (This is where your bill will be sent.) ☐Same as Person Above

Last Name: _____ First Name: _____ M.Name + Suffix: _____

Street Address / P.O. Box: _____ Apt. / Lot #: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ SSN: _____ Phone: _____

PRIMARY INSURANCE INFORMATION Name of Insurance Carrier: _____

Patient's Relationship to Policy Holder: ☐Self ☐Spouse ☐Child ☐Other: _____

Last Name: _____ First Name: _____ M.Name + Suffix: _____

Policy #: _____ Date of Birth: _____ SSN: _____

SECONDARY INSURANCE INFORMATION Name of Insurance Carrier: _____

Patient's Relationship to Policy Holder: ☐Self ☐Spouse ☐Child ☐Other: _____

Last Name: _____ First Name: _____ M.Name + Suffix: _____

Policy #: _____ Date of Birth: _____ SSN: _____

I consent to treatment for myself or above minor child. I understand that the examination and/or medical treatment I will receive is NOT intended to replace complete medical care by my personal Primary Care Physician. It is important for you to understand that the patient is ultimately responsible for knowing their individual benefits/coverage and is responsible for any fees that are not covered by their insurance provider, including durable medical equipment (splints, crutches, ace wraps, etc.). If you have any questions concerning the coverage your plan may have with QuickCARE of Ruston, please contact your insurance provider.

I have reviewed and agree with the above information. I certify that the information I have provided is true and correct to the best of my knowledge.

_____ _____

Patient Signature (if minor, signature of Parent/Guardian) Date