OnSite Care Clinics
560 S 300 E, Suite 275
Salt Lake City, Utah, 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 _____

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 and that I could be subject to a payroll deduction and/or collection fees up to 40% for any outstanding balance and I provide consent for OnSite Care and any collection agency to contact me directly regarding any outstanding balance.

I authorize OnSite Care to view my prescription history through external sources.

_____ _____

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.

_____ _____

Signature of Patient/Guardian *Date*

Revised 10/22/2015