BEE WELL URGENT CARE

6650 Eastgate Blvd, Suite 104   Lebanon, TN 37090
615.900.5451 / fax 615.900.5440

INTAKE FORM

Patient LEGAL name: _____DATE: _____

Preferred name: _____ Gender: Male   Female   Decline

Race: AA/black   Caucasian/white   Asian   Native American   Other   Decline

Ethnicity: Hispanic/Latino   Non-Hispanic/Latino   Other   Decline

Address:_____City/State/Zip:_____

Birthdate: _____ SSN#: _____

Relationship status: Single   Married   Divorced   Widowed   Other:_____

Phone: _____ May we leave messages at this number?   YES   NO

Email: _____

Preferred pharmacy: _____

EMERGENCY contact name/relationship: _____

EMERGENCY contact phone: _____

**HIPAA LAW PROHIBITS SHARING OF YOUR PERSONAL MEDICAL INFORMATION UNLESS YOU ASK US
TO RELEASE IT. YOU MAY REVOKE THIS PERMISSION ANY TIME BY SUBMITTING A WRITTEN REQUEST.
LIST THOSE BELOW YOU PERMIT ACCESS TO YOUR PRIVATE INFORMATION.**

Name/relationship: _____ Phone: _____

Name/relationship: _____ Phone: _____

Name/relationship: _____ Phone: _____

Please COMPLETE ALL INFORMATION below AND present your insurance card(s) with driver's license prior to being treated.

PRIMARY Insurance: _____

Member ID#:_____   Group #:_____

If someone OTHER THAN THE PATIENT is the policy holder, please complete the following:
(policy holder can be parent, spouse or other guardian who controls the plan)

Policy Holder's name:_____ DOB: _____

SSN# (required):_____

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SECONDARY Insurance: _____

Member ID#:_____   Group #:_____

If someone OTHER THAN THE PATIENT is the policy holder, please complete the following:
(policy holder can be parent, spouse or other guardian who controls the plan)

Policy Holder's name:_____ DOB: _____

SSN# (required):_____

MANAGEMENT OF CREDITS TO YOUR ACCOUNT:

Credits may appear on your account from time to time related to overpayments, refunds, or insurance determined adjustments. If this occurs, please indicate below how you would like those managed. You may submit a written request to adjust this decision at any time.

_____ Leave balance on account for future use

_____ Issue a refund check to my address on file

SIGNATURE: _____ DATE:_____