Patient sign-in form **Dr. Brian Carey** **Tryon Urgent and Family Care**

Please fully complete this form and return with insurance card and photo i.d.

Date of service____/____/_____ Time-in______ Appointment time ______ Walk in ___ Work Comp? Y__N__

Patient name (printed) ____ Date of birth_______/_______/__________

Reason for today's visit:((1)____________________________________(2) ____________________________________

SS# ___________________________ Gender M____F_____ Primary Care Doctor:_______________________________

Patient address____________________________________ City________________ State_____ Zip__________

Patient Billing address ___________________________________ City________________ State _____ Zip______________

Home phone: _____________________ **Cell**: _____________________ **Work phone**_______________________________

If only cell phone is listed, please provide secondary telephone number for contact ____________________________

Employer Name _________________________ Patient Email address:____

Emergency contact person: ______________________ Telephone _______________________ Relationship to patient___________

Contact preference: Home__ Cell __Work __Email __ May we leave messages? Y__N__ **(Please unblock for private callers)**

Preferred language: English ___ Spanish ___ Other ___ Refused ___

Race: White___ Black ___ American Indian ___ Hispanic ___ Asian ___ Other ___ Refused ___

Marital status: Married ___ Single ___ Divorced ___ Widowed ___ Child ____

Preferred local pharmacy: ____________________Location :______________________ Mail away pharmacy? Y___N____
If using mail away pharmacy, you must provide address and telephone number at time of visit.

I have received copy of the HIPPA / Privacy document and verify my understanding of how my medical records / information will be protected:

Patient signature:_____________________________________ **Date**_____/_____/______

Guardian Signature:_________________________**Relationship to patient:**_________________

Medication list (please give all prescription bottles to nurse at time of visit)

Rx name:_______________________ dose__________ Rx name:___________________________ dose__________

Rx name:_______________________ dose__________ Rx name:___________________________ dose__________

Section below line for Parent / Guarantor / Primary Insurance holder / Person responsible for payment information

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Name (please print) ____________________________________ Birthday ____/____/______ Gender: M___F____

SS # _____________________________________ Relationship to patient: ____________________

Address: ___________________________________ City _________________ State________ Zip_____________________

Home: _____________________ Cell _____________________ Work_____________________Employer_______________