



WELCOME

Thank you for trusting us with your urgent care needs. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to ask us.

Date: _____

Office Use Only	
ID # _____	Amount Pd \$ _____
Entered/Collected By _____	

PATIENT INFORMATION

Reason for today's visit _____

If this is a return visit within 30 days, please state a reason _____

Last Name _____ First Name _____ MI _____ Birthdate _____
 SS# _____ E-mail address _____
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Cell Phone _____ Work Phone _____
 Gender M__ F__ Marital Status M__ S__ D__ W__ Other _____ Preferred Language _____
 Primary Care Physician/Phone _____ Ethnicity: Hispanic/Latino or Non-Hispanic
 Parent/Guardian (if minor) _____ Race: Asian or American Indian or Alaskan or
 Employer/Phone _____ African American or Pacific Islander or White
 Employer Address _____

How Did You Hear About Us? Direct Mail__ Internet__ Referral__ Family/Friend__ Phone Book__ Newspaper__
Driving By__ Other_____

PATIENT INSURANCE INFORMATION

Primary Insurance _____	Secondary Insurance _____
Policy # _____	Policy # _____
Group # _____	Group # _____
Policy Holder's Name _____	Policy Holder's Name _____
Relationship to Patient _____	Relationship to Patient _____
Address if different than Patient's _____	
Employer and Address _____	

I have read and answered the above questions to the best of my knowledge. I will not hold Velocity Urgent Care or its partners and employees responsible for any errors or omissions that I may have made in completing this form.

Signature of patient or parent/guardian if minor Date

If this is a return visit within 30 days for any reason, please sign again below:

Signature of patient or parent/guardian if minor Date

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365 Queen Street, Southington, CT 06489

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Tel 860-863-5835 Fax 860-863-5838 Urgent Care of Southington LLC

