URGENT CARE at Harrington express

ONLINE CHECK-IN PATIENT INTAKE FORM

PATIENT INFORMATION

Full Name _____

Date of Birth: _____
MM/DD/YYYY

Address:

_____
Street Apartment Number

_____
City State Zip Code

Phone Number: _____

PRIMARY CARE PROVIDER INFORMATION

Physician Name: _____

INSURANCE INFORMATION

Primary Insurance: _____

Insurance ID #: _____

Policy Holder's Name: _____

Relationship to Subscriber: _____

Policy Holder's Birth Date: _____
MM/DD/YYYY