



Kootenai Urgent Care Coeur d' Alene Office - Sign in Sheet

Date: _____ Time: _____ AM PM

Patient Information

Name: _____ Gender: M F

Date of Birth: _____ Social Security #: _____

Mailing Address: _____

City, State: _____ Zip: _____

Home Phone: _____ Cell Ph: _____ Best to call: Home Cell

Family Physician: _____ None

Responsible Party: _____ DOB: _____ SS# _____

Address: Same as Patient Other – Use back of sheet

Insurance Information No Insurance

Insurance: _____ 2nd Insurance: _____

Insurance Policyholder: _____ DOB: _____ SS# _____

(Name & Relationship)

Address: Same as Patient Other – Use back of sheet

Reason for visit / symptoms? _____

Have you been seen in Kootenai Urgent Care before? YES NO

E-mail address:

May we contact you by phone regarding this visit? YES NO

Is this a work related injury? YES NO
