Kootenai Urgent Care

Hayden 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

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

Is this a work related injury? ❑ YES ❑ NO

E-mail address:

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