BRIDGEPORT EXPRESS CARE

Urgent Care & Family Practice

PATIENT INFORMATION					
Patient's Last Name: First: Middle:		Mrs. Mr.	Miss Ms	Marital Status (Circle One): ☐ Single ☐ Married ☐ Divorced ☐ Widow	
Social Security No.:	Birth Date:	Sex:	Here for: ☐ **Urgent Care** ☐ **Primary Care**		
Street Address:		City:		State:	Zip Code:
Home Phone No.:	Cell Phone No.:			Employer Phone No.:	
Occupation:	Employer:			Pharmacy:	

IN CASE OF EMERGENCY			
Local Friend or Relative with different address:	Relationship to patient:	Home Phone No.:	Work/Cell Phone No.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance remaining. I also authorize Bridgeport Express Care or my insurance company to release any information required to process my claims.

Patient/Guardian Signature_____ Date_____/_____/_____

Controlled Substances Notice

Bridgeport Express Care does not routinely prescribe long term controlled medications. In the event you have a medical condition that requires a short course of a controlled medication as evidenced by x-ray (such as a fracture) a maximum of five days will be prescribed at the provider's discretion. Refills will not be given and you will need to follow up with your primary care provider for further prescriptions. Prior to any controlled substances, a urine drug screen will be obtained and the provider will run a report from the board of pharmacy to review your prescription history. I acknowledge that I have received and understand the above notice.

Patient/Guardian Signature_____ Date_____/_____/_____

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Fax: 304-842-3303 **www.expresscarebridgeport.com**