ACT FAST MEDICAL CARE

PATIENT INFORMATION SHEET

DATE: _____

First Name: _____ MI___ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Mobile Phone: _____

SS #: _____ DOB: _____ Age: _____

Sex: M F Marital Status: S M D W

Race: Caucasian African American Middle Easterner Hispanic Other
(Please circle one)

Previous Primary Care Physician: _____

Insurance Carrier Information:

First Name: _____ Last Name: _____

SS# _____ DOB: _____

Occupation: _____ Employer: _____

Emergency Contact:

Name: _____

Primary Phone #: _____

Relationship to you: _____

Act Fast Medical Care utilizes a patient portal for your convenience, through eDoctorLink PCG Way. After this visit you will be sent an invitation to the email address provided below in order to access, view, and download the information from today's visit. Please note that the email address provided below will become your portal account username and you will be prompted to use a temporary password until you can create your own. Please maintain your own password as well as the answers to your security questions; Act Fast Medical Care does not maintain this information for you. Also please note that:

- Sharing an email address with another patient (i.e. husband, wife, mother, son, etc.) will result in linked accounts and thus shared medical records for patient(s) to view.
- If you do not wish to provide an email address to Act Fast Medical Care, please note that this is a declination to access your information on the portal. To indicate this intent, please select the box before signing.
- If your email address changes after your visit with us, please note that the email you initially provided will continue to be your username. You will want to note this for your records.

Email Address: _____

□ I decline to provide my email address and thus refuse access to view, download and/or transmit my records from Act Fast Urgent Care.

Patient Signature: _____ Date: _____