THE MED STATION
WALK-IN MEDICAL CARE
Primary and Urgent Care for Children & Adults
FAMILY PRACTICE

How did you hear about us? Please circle below or fill:

Facebook Google Yelp Bing Website Family/Friend Employer Posters/Flyers Business Cards Insurance Referred by Doctor Chamber of Commerce Others/Specify:

REASON OF VISIT

Chief Complaint/Reason of Visit:_____
Allergies: _____ Work related reason? Y / N (circle) If Yes, Was it reported? Y / N (circle)

PATIENT INFORMATION

Last Name_____ First Name_____ MI_____
Date of Birth_____ Age_____Sex_____ Marital Status_____Social Security #_____
Address_____City_____State____ Zip_____
Home Phone_____ Cell Phone_____ Work Phone_____
e-mail _____ Employer:_____
Employer Address:_____

IF PATIENT IS A MINOR: PARENT/GUARDIAN INFORMATION

Last Name_____ First Name_____ MI_____
Date of Birth_____ Age_____Sex_____ Marital Status_____Social Security #_____
Address_____City_____State____ Zip_____
Home Phone_____ Cell Phone_____ Work Phone_____
e-mail _____ Employer:_____
Employer Address:_____

INSURANCE INFORMATION

Payment is expected at time of service: Copays/Partial or Full Deductibles/Past Balances
Forms of Payment: Cash Check Credit Card (Visa, Master Card, Discover, American Express), Venmo, Zelle
Insurance Company:_____ Insurance Member ID# _____
Group # _____ Insurance Address: _____

Disclosure: *In cases that your insurance requires The Med Station to be your PCP (Primary Care Provider) in order for the insurance to financially cover your visit, you may be required to change to us as your PCP at least temporarily before you can be seen. We will try to assist you in this transition. Some insurances have us as a Primary Care only or as an Urgent Care only. PCP Change should be listed under Debbie Feliciano M.D.*

I hereby authorize payment of medical benefits to The Med Station for services rendered. I also authorize the release of any information necessary to process a claim

Patient/Guardian/Parent Signature_____ Date_____

SPECIAL REQUEST FOR CONFIDENTIAL COMMUNICATIONS

I make the following special request for confidential communications:

_____

_____

_____

_____

AUTHORIZATION OF SHARED MEDICAL INFORMATION / COMMUNICATION

I authorize The Med Station to share any of my medical information/records and commuincations in my behalf to the following:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____

I have read and received a paper copy of the Privacy Notice and am aware that a copy is available for my records.

_____	_____	_____
Patient / Parent / Guardian Full Name	Patient / Parent / Guardian Signature	Date