ultiMED
urgent medical care
707 Paseo de Peralta Santa Fe, NM 87501

ph 505.989.8707
fax505.989.3536

SSN (last 4#s required): _____ Today's Date: _____

First Name: _____ Home Phone#: _____

Last Name: _____ Cell Phone#: _____

Preferred Name: _____ Gender Preference: **M** □ **F** □

Date of Birth: ____/____/____
Month Date Year

Email: _____

Mailing Address: _____ _____ _____ _____
Street or PO Box City State Zip

Local Address
(if visiting from out of town):

Reason for today's visit:

Is this a work related injury? □ Yes □ No

If Yes – Name of Work: _____ Work Phone: _____

HR Contact or Work Supervisor:

How did you hear about us?

Primary Insurance: _____

Secondary Insurance: _____

Primary Insurance Holder's Name: _____

Primary's Date Birth: Relationship to Patient:

I consent to medical treatment by ultiMED for myself or a minor child for whom I am accepting medical and financial responsibility. Upon request, my rights and privileges for privacy and accessibility to my medical records will be explained to me. I realize that my insurance company may not cover all of my expenses and that I may be responsible for any charges that exceed their coverage.

Date: _____ Parent Signature: _____

Patient: _____ Other Adult Signature: _____
(signature)

Relationship to Patient: _____