



**Temecula**  
**24 Hour Urgent Care**

We're here when you need us.

41715 Winchester Road Ste. 101  
Temecula, CA 92590  
Ph: 951.308.4451 | Fax: 951.506.0992



**Carlsbad**  
**Urgent Care**

We're here when you need us.

2804 Roosevelt Street  
Carlsbad, CA 92008  
Ph: 760.720.2804 | Fax: 760.720.7400



**Carlsbad Urgent Care**  
**San Marcos**

We're here when you need us.

295 S. Rancho Santa Fe Road  
San Marcos, CA 92078  
Ph: 760.471.1111 | Fax: 760.471.1001

**PATIENT INFORMATION FORM**  
**INFORMATION TO BE FILLED OUT COMPLETELY**

PATIENT NAME: \_\_\_\_\_, \_\_\_\_\_ SEX: MALE FEMALE  
Last Name First Name

DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ APT.#: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE #: \_\_\_\_\_ CELL PHONE #: \_\_\_\_\_

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

EMERGENCY CONTACT: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

EMERGENCY CONTACT DATE OF BIRTH: \_\_\_\_\_ CONTACT'S PHONE #: \_\_\_\_\_

**INSURANCE INFORMATION or SELF-PAY (No Insurance)**

**PRIMARY INSURANCE:**

**CHECK ONE:** SELF-PAY (No Insurance) PPO HMO POS EPO

**If Insured, complete the following questions:**

I, the Patient, **AM** the Primary Subscriber for this Insurance.

I am **NOT** the Primary Subscriber for this Insurance.

If **NOT** the Primary, the Primary Subscriber's Name is: \_\_\_\_\_

Relationship to Primary Subscriber: \_\_\_\_\_ Primary Subscriber's SSN: \_\_\_\_\_

Primary Subscriber's Date of Birth: \_\_\_\_\_ Primary Subscriber's Phone: \_\_\_\_\_

Primary Subscriber's Address: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

**SECONDARY INSURANCE:**

**CHECK ONE:** PPO HMO POS EPO

I, the Patient, **AM** the Primary Subscriber for this Insurance.

I am **NOT** the Primary Subscriber for this Insurance.

If **NOT** the Primary, the Primary Subscriber's Name is: \_\_\_\_\_

Relationship to Primary Subscriber: \_\_\_\_\_ Primary Subscriber's SSN: \_\_\_\_\_

Primary Subscriber's Date of Birth: \_\_\_\_\_ Primary Subscriber's Phone: \_\_\_\_\_

Primary Subscriber's Address: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_



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### Authorization / Consent

- I hereby consent to and authorize the administration of all diagnostic and therapeutic treatments that may be considered advisable or necessary in the judgment of the medical provider.
- I hereby authorize the medical provider to release any information acquired in the course of my examination or treatment as needed for payments or authorizations for tests, procedures, referrals or any other services deemed medically necessary.
- I hereby authorize payment directly to the medical provider, of benefits otherwise payable to me, for service rendered.

PRINT NAME \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
*(Patient or Guardian):* \_\_\_\_\_  
 SIGNATURE \_\_\_\_\_ DATE: \_\_\_\_\_  
*(Patient or Guardian):* \_\_\_\_\_

### Authorization to Release Medical Information

#### Release Records To:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

#### HIPAA AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION:

I voluntarily authorize the above Releasing Entity to use and disclose my health information.

PRINT NAME \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
*(Patient or Guardian):* \_\_\_\_\_  
 SIGNATURE \_\_\_\_\_ DATE: \_\_\_\_\_  
*(Patient or Guardian):* \_\_\_\_\_

**Please initial the following spaces** if you have read and understand the following policies and have reviewed copies of these policies:

\_\_\_\_\_ Member Eligibility / Covered California Waiver  
 \_\_\_\_\_ Financial Policy  
 \_\_\_\_\_ HMO / Self-Pay Waiver



**Which Clinic are you visiting today?**

Temecula 24 Hr. Urgent Care  
 Carlsbad Urgent Care  
 Carlsbad Urgent Care – San Marcos



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**MEDICAL QUESTIONNAIRE**  
**INFORMATION TO BE FILLED OUT COMPLETELY**

PATIENT NAME: \_\_\_\_\_, \_\_\_\_\_ SEX:      MALE      FEMALE  
Last Name      First Name

DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_

REASON FOR TODAY'S VISIT: \_\_\_\_\_

Duration of Symptoms: \_\_\_\_\_      Is this potentially a      **YES**      Is this a work related      **YES**  
 Medical Legal Claim?      **NO**      injury?      **NO**

**NOTE:** If you are here ONLY for a Department of Transportation drug or alcohol screening, the section below is optional.

YES	NO		YES	NO		YES	NO	
		CHEST PAIN / PRESSURE			FAINTING SPELLS / LOSS OF CONSCIOUSNESS			DIFFICULTY BREATHING
		PAINFUL URINATION			COUGH			FREQUENT URINATION
		HEAD INJURY			FEVER			CHANGE IN URINE COLOR
		RASH			UNINTENDED WEIGHT LOSS / GAIN (20 lbs. in 6 months)			CHRONIC or RECURRENT BACK PAIN
		EYE PAIN			IRREGULAR HEARTBEAT			PAIN IN JOINTS
		BLURRY VISION			ABDOMINAL PAIN			MUSCLE PAIN
		DOUBLE VISION			HEARTBURN / GERD			MUSCLE WEAKNESS
		EAR PAIN / EAR PRESSURE			NAUSEA			HEADACHE
		RECENT DECREASED HEARING			VOMITING			LIGHTHEADEDNESS
		LOSS OF APPETITE			DIARRHEA			DIZZINESS
		PAINFUL BREATHING			CONSTIPATION			NUMBNESS / TINGLING
		ABNORMAL BREATHING SOUNDS / WHEEZING			BLOODY or BLACK STOOL			EXCESSIVE THIRST & URINATION



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## VERIFICATION OF BENEFITS CHECKLIST

- Call **MEMBER SERVICES** (This phone number located on ***back*** of insurance card)
- Provide your **NAME, DATE OF BIRTH, MEMBER ID, and GROUP NUMBER** to the **MEMBER SERVICES** representative. (The Member and Group ID Numbers are located on ***front*** of insurance card)
- Verify the clinic you are going to visit is **IN-NETWORK** (If not **IN-NETWORK**, ask about your **OUT-OF-NETWORK BENEFITS**.)
- Ask about your **CO-PAY, CO-INSURANCE, and DEDUCTIBLE**.
- Have **MEMBER SERVICES** immediately fax the **ELIGIBILITY AND BENEFITS REPORT** to the clinic you are seeking care and treatment:

**TEMECULA: 951-506-0992**  
**CARLSBAD: 760-720-7400**  
**SAN MARCOS: 760-471-1001**

- Obtain a **REFERENCE NUMBER** regarding your call for your documentation and records.

Example of Insurance Card:

**Anthem**  
Blue Cross

University of California  
Student Health Insurance Plan

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UC Santa Barbara

**John O. Member**  
Identification Number  
**MEMBER ID H0123456789**

Group No: **UCSBP**  
Plan Code: **UJU**  
Rx Bin: 610053  
Coverage(s): Pharmacy – Medical  
WGS Data: PLAN DESCRIPTION 2

Copays Outside of Student Health  
General Med Office Visit \$15  
Specialist Office Visit \$20  
Behavioral Health Visit \$15  
**Urgent Care Clinic Visit \$50**  
Emergency Room visit \$100

**FRONT OF INSURANCE CARD**

**Blue Cross PPO**  
A Prudent Buyer Plan Product

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**Anthem**  
Blue Cross

www.ucop.edu/ucship

SHS Website\* studenthealth.sa.ucsb.edu  
Student Health Services\* 1-805-893-3371  
UCSB Insurance Office\* 1-805-893-2592  
UCSB Counseling Services\* 1-805-893-4411

**MEMBERS:** When submitting inquiries always include your member number from the face of this card. Possession or use of this card does not guarantee payment.

**PROVIDERS:** Please submit claims to your local Blue Cross and/or Blue Shield Plan. To ensure prompt claims processing, include the 3-digit alpha prefix that precedes the patient's identification number filled on the front of this card.

Prior referral by a Student Health Svcs provider is required for all non-emergency medical care.

**CLAIMS & INQUIRIES:**  
P.O. BOX 60007 LOS ANGELES, CA 90060

**Member Services** 1-866-948-8308  
Pharmacy 1-866-219-1936  
Coverage While Traveling 1-800-810-2583  
Pre-Authorization Review 1-800-274-7767  
24/7 NurseLine 1-877-351-3457

\*Not a Blue Cross Blue Shield Product

Anthem Blue Cross Life and Health Insurance Company provides administrative services only and does not assume any financial risk or obligation with respect to claims. Blue Cross of California, using the trade name Anthem Blue Cross, administers claims on behalf of Anthem Blue Cross Life and Health Insurance Company and is not liable for benefits payable. Independent licensees of the Blue Cross Association.

**BACK OF INSURANCE CARD**