PROFESSIONAL URGENT CARE SERVICES

ST. PETE
640 TYRONE BLVD N 33710
727-528-7827

TAMPA
6182 GUNN HWY 33625
813-568-4388

(please contact your chosen location by phone before completing this form.)

EMAIL COMPLETED FORM TO **INFO@PROFESSIONALURGENTCARE.COM**

EMERGENCY MEDICAL CONDITION (EMC/MVA) REQUEST

EMC: ☐ or MVA: ☐

Patient Name:_____ Patient Date of Birth: _____
Insurance Carrier: _____ Medical Claim #:_____
Patient Phone Number: _____ Date of Accident:_____

Referring Office/Organization

Were you referred to us? ☐Yes ☐No
If **YES**, please provide the following information:
Office/Organization Name: _____
Phone Number: (_____) _____
Fax Number: (_____) _____
Designated Representative Name:
_____

Attorney Information

Is there an attorney assigned to the case? ☐Yes ☐No
If **YES**, please provide the following information:
Law Office Name: _____
Attorney Name: _____
Phone Number: (_____) _____
Fax Number: (_____) _____

Requested Services

X-ray

☐ C-Spine
☐ T-Spine
☐ L-Spine
☐ Hips/Pelvis
☐ SI Joints
☐ Knee R / L
☐ Ankle R / L
☐ Foot R / L
☐ Additional Imaging:
_____

Medication Management

☐ NSAIDs
☐ Muscle Relaxers
☐ Topical Analgesics
☐ Other: _____

Request for Medical Records

This signed form authorizes the release of medical records information necessary for billing or continuity of care. If there are specific records needed for this patient, please check information to be released:

☐ **All Records**
☐ If specific item(s) requested, please specify: _____
Preferred method to receive requested records:
☐ Secure Fax
☐ Mail

Patient (or Authorized Representative) Signature: _____Date: _____