Patient Registration Form

First Name: _____ Last: _____ Middle:_____

SSN: _____ Birthday:_____ Gender (please circle): Male Female

Home Phone: _____ Cell Phone: _____

Address: _____

City: _____ St: _____ Zip: _____

Email: _____ Would you like informational emails from us? Yes No

Who should we call if there is an EMERGENCY for you? _____

What is the best number to call your EMERGENCY person? _____

Marital Status (please circle): Divorced Married Separated Single Unknown Widowed

Are you of Hispanic Ethnicity? (please circle) Yes No Preferred Language: _____

Is this a work related visit? (please circle) Yes No

How did you hear about us? _____ Who is your Primary Medical Provider? _____

Employer Name: _____

Employer Address: _____

Employer City: _____ St: _____ Zip: _____

Employer Phone: _____

Primary Insurance:_____

Your Urgent Care Copay:_____

Policyholder Name:_____

Relationship to you:_____

Policyholder SSN:_____

Policyholder DOB:_____

Secondary Insurance:_____

Your Urgent Care Copay:_____

Policyholder Name:_____

Relationship to you:_____

Policyholder SSN:_____

Policyholder DOB:_____

(Please complete this section if patient is under 18)

Guarantor Name: _____ Relationship: _____

Guarantor Address: _____ City: _____ St: _____ Zip: _____

Guarantor Birthdate: _____ Guarantor SSN: _____ Guarantor Gender: _____

Guarantor Employer Name: _____

Guarantor Employer Address: _____

Guarantor Employer City: _____ St: _____ Zip: _____