

PATIENT REGISTRATION FORM

Patient ID:		Please fill out this form completely!	
Social Security No:	Email Address:		
Patients Full Name:	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced		
Date of Birth:	<input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Child		
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone:		
Street Address:	Cell Phone:		
Apt./Unit/Suite #:	Employer:		
City, State, Zip:	Work Phone:		
Emergency contact name:	Primary Care Physician:		
Emergency Phone:	How did you hear about us?		
Relationship to Patient:	Based on the government regulations we are required to gather the following information:		
REASON FOR VISIT:	PREF. LANGUAGE: English Other _____		
	ETHNICITY: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic		
	RACE: <input type="checkbox"/> Decline <input type="checkbox"/> White <input type="checkbox"/> Black or African America		
	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian		
If patient is under 18 yrs. of age, parent signature required below:	<input type="checkbox"/> Native Hawaiian or other Pacific Islander		
Parent/Guardian Signature:	PREFERRED CONTACT METHOD: CIRCLE ONE		
	CELL#	H#	W#

REQUIRED INSURANCE INFORMATION:

Please Complete Primary Policy Holders Information:	
Primary Insurance Company:	Policy Holders Name:
Member ID:	Policy Holders DOB:
Group Number:	Policy Holders SSN:
Copay:	Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Spouse

IF THERE IS SECONDARY OR SUPPLEMENTAL INSURANCE, PLEASE COMPLETE THIS PORTION:

Secondary/Supplemental Insurance Company:	
Member ID:	Group Number:
Copay:	

It is our policy to collect payment of all charges incurred at the time services are rendered. All patient balances over 30 days will be charged a late fee of \$10.00. In the event payment is not made on an account, the patient/responsible party agrees to pay for all costs associated with the collection of the debt (attorney's fees and collection costs). Please note, we do not bill third parties for your visit, i.e. Personal Injury Protection Insurance, Lawyers or other parties.

I have reviewed the 8-2-8 Urgent Care Financial Policy. I agree to all terms and conditions and accept financial responsibility in full for this account, in the event of nonpayment from my insurance carrier.

***Signed:** _____

***Date:** _____