8-2-8 URGENT CARE
8 to 8 DAILY
... Yes, even holidays!

INSURANCE

4171 Oceanside Boulevard, Suite 109
Oceanside, California 92056
Phone: 760-216-6253 Fax: 760-216-6283
Monday – Sunday 8:00am – 8:00pm
OPEN EVERYDAY OF THE YEAR!!!

PATIENT REGISTRATION FORM

Patient ID:	**Please fill out this form completely!**
Social Security No:	Email Address:
Patients Full Name:	Marital Status: ☐ Single ☐ Married ☐ Divorced
Date of Birth:	☐ Widowed ☐ Separated ☐ Child
Sex: ☐ M ☐ 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:	Do you have a medication list with you? ☐ Yes ☐ No
REASON FOR VISIT:	Preferred Pharmacy/Location:
	Based on the government regulations we are required to gather the following information:
	PREF. LANGUAGE: English Other _____
If patient is a minor, Parent Signature required below:	ETHNICITY: ☐ Hispanic or Latino ☐ Non-Hispanic
Parent/Guardian Signature:	RACE: ☐ Decline ☐ White ☐ Black or African American
Relationship to Patient: ☐ Mother ☐ Father	☐ American Indian or Alaskan Native ☐ Asian
☐ Step-Parent ☐ Grandparent ☐ Legal Guardian	☐ Native Hawaiian or other Pacific Islander

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: ☐ Self ☐ Parent ☐ 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: _____