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

# Self-Pay

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 America |
| Relationship to Patient: ☐ Mother ☐ Father | ☐ American Indian or Alaskan Native ☐ Asian |
| ☐ Step-Parent ☐ Grandparent ☐ Legal Guardian | ☐ Native Hawaiian or other Pacific Islander |

☐ NO PROCEDURES

## Self-Pay Fee Slip

| X-Rays | Injections/Immunizations | Labs / Procedures | Lacerations/Other |
|---|---|---|---|
| ☐ Cervical Spine 72040 | ☐ Ceftriaxone/Rocephin J0696 | ☐ CBC /CMP85025/80053 | ☐ Wound Repair 12001 |
| ☐ Lumbar Spine 72100 | ☐ Solu-Medrol J2930 | ☐ UA / HCG 81003/81025 | ☐ I & D Abscess 10060 |
| ☐ Chest/Ribs 2V 71046 | ☐ Toradol J1885 | ☐ Strep Test 87430 | ☐ Dermabond G0168 |
| ☐ Shoulder 3V 73040 | ☐ Phenergan J2550 | ☐ Influenza Test 87804 | ☐ Nebulizer 94640 |
| ☐ Wrist/Hand73110/73130 | ☐ Influenza 90658 | ☐ EKG 93000 | ☐ GI Cocktail 99070 |
| ☐ Ankle/Foot 73610/73630 | ☐ Tdap/TD 90715/90718 | ☐ Ear Lavage 69210 | ☐ IV Hydration 96360 |
| ☐ Other: | ☐ Other: | ☐ Other: | ☐ Other: |

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: _____