

## Community Urgent Care & Family Medicine REGISTRATION FORM

(Please Print)

| Today's Date:  |  |                                  |  | PCP:  |        |  |           |
|--|--|----------------------------------|--|---|--------|--|-----------|
| PATIENT INFORMATION  |  |                                  |  |   |        |  |           |
| Patient's last name:   |  | First:                           |  | Middle:                                     |        | <input type="checkbox"/> Mr. <input type="checkbox"/> Miss<br><input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.   |           |
|  |  |                                  |  |   |        | Marital status:<br>Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid <input type="checkbox"/> |           |
| Is this your legal name?   |  | If not, what is your legal name? |  | (Former name):                              |        | Birth date:  |           |
| <input type="checkbox"/> Yes <input type="checkbox"/> No           |  |                                  |  |   |        | Age:   |           |
|  |  |                                  |  |   |        | Sex:<br><input type="checkbox"/> M <input type="checkbox"/> F  |           |
| Street address:  |  |                                  |  | Social Security no.:                        |        | Home phone no.:  |           |
|  |  |                                  |  |   |        | (    )   |           |
| P.O. box:  |  | City:                            |  |   | State: |  | ZIP Code: |
|  |  |                                  |  |   |        |  |           |
| Occupation:  |  | Employer:                        |  |   |        | Employer phone no.:  |           |
|  |  |                                  |  |   |        | (    )   |           |
| Chose clinic because/referred to clinic by (Please check one box): |  |                                  |  | <input type="checkbox"/> Dr.                |        | <input type="checkbox"/> Insurance plan <input type="checkbox"/> Hospital  |           |
| <input type="checkbox"/> Family                                    |  | <input type="checkbox"/> Friend  |  | <input type="checkbox"/> Close to home/work |        | <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Other   |           |
| Other family members seen here:                                    |  |                                  |  |   |        |  |           |

| INSURANCE INFORMATION                                  |  |  |  |                                 |  |   |  |
|--|--|--|--|---------------------------------|--|---|--|
| (Please give your insurance card to the receptionist.) |  |  |  |                                 |  |   |  |
| Person responsible for bill:                           |  | Birth date:  |  | Address (if different):         |  | Home phone no.:   |  |
|  |  |  |  |                                 |  | (    )  |  |
| Is this person a patient here?                         |  | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |                                 |  |   |  |
| Occupation:  |  | Employer:  |  | Employer address:               |  | Employer phone no.:   |  |
|  |  |  |  |                                 |  | (    )  |  |
| Is this patient covered by insurance?                  |  | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |                                 |  |   |  |
| Please indicate primary insurance                      |  | <input type="checkbox"/>                                 |  |                                 |  |   |  |
| Subscriber's name:                                     |  | Subscriber's S.S. no.:                                   |  | Birth date:                     |  | Group no.:  |  |
|  |  |  |  |                                 |  | Policy no.:   |  |
|  |  |  |  |                                 |  | \$  |  |
| Patient's relationship to subscriber:                  |  | <input type="checkbox"/> Self                            |  | <input type="checkbox"/> Spouse |  | <input type="checkbox"/> Child <input type="checkbox"/> Other |  |
| Name of secondary insurance (if applicable):           |  | Subscriber's name:                                       |  |                                 |  | Group no.:  |  |
|  |  |  |  |                                 |  | Policy no.:   |  |
|  |  |  |  |                                 |  |   |  |
| Patient's relationship to subscriber:                  |  | <input type="checkbox"/> Self                            |  | <input type="checkbox"/> Spouse |  | <input type="checkbox"/> Child <input type="checkbox"/> Other |  |

| IN CASE OF EMERGENCY   |  |                          |  |
|--|--|--------------------------|--|
| Name of local friend or relative (not living at same address):   |  | Relationship to patient: |  |
|  |  |                          |  |
| Home phone no.:  |  | Work phone no.:          |  |
| (    )   |  | (    )                   |  |
| The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims. |  |                          |  |
| Patient/Guardian signature   |  | Date                     |  |
|  |  |                          |  |