Urgent Care Plus

Patient Registration Form

Please print all responses.

Patient Name: Last _______________________ First ____________________ Middle Initial ____

Social Security number ________-________-________ DOB _____/_____/_____ Sex ___ M ___ F

Address: _________________________City: _____________ State: _____ Zip Code ___________

Phone numbers: Home (___) _____-______ Work (___) _____-______ Mobile (___) _____-______

May we leave a voice mail? ___ Yes ___ No

Email address: ____@_____________________

Is today's visit accident related? ______**YES** _________**NO**
If YES, have you filled out the required Workman's Comp forms?
If not, please ask the front office staff.

Do you require an interpreter? ___ Yes ___ No

What is your primary language? ____

What is your marital status? ____Single ____ Married ____Divorced ____Widowed ____Other

What is your religious preference? _________________ ___I prefer not to answer

The U.S. government requires that we ask the following questions:

How do you identify your ethnicity?

_____ Hispanic or Latino _____ NOT Hispanic or Latino _____ I prefer not to answer

How do you identify your race?

_____ American Indian or Alaska Native _____ Asian _____ Black or African American

_____ Native Hawaiian or Other Pacific Islander _____Other

_____ White or Caucasian _____ I prefer to not answer

Patient Name: ___________________________________ **DOB:** _________________________

Your Employment Status:

___ Full Time ___ Part Time ___ Self Employed
___ Retired ___ Student ___ Not Employed

Employer Name: ____

How many employees in the company? ___ 1-19 ___20-99 ___100+

Do you have health insurance? ___ Yes ___ No

Who is the subscriber, or policy holder?

____

Relationship to you? ___Self ___Parent ___Spouse ___Other

Subscribers date of birth _______/________/_________

Subscribers Social Security Number _______-______-_________

Is the insurance through an employer? ___ Yes ___ No

Who is your Primary Care Physician? ____

Who would you like to list as your emergency contact?

Name: _______________________________________ Relationship: ________________________

Address: __________________________________Zip _______ Phone :(______) ______-_________

For Minor Children

Who is the guarantor/person financially responsible for your account?

____

Relationship ______________ Date of Birth: _________ Social Security Number _____-_____-_____

Address: _______________________________________ Phone :(______) ______-_____________

Patient Signature: ____ Date: _________________