Urgent Care Management
We Care

Patient Information

MR#:_____ Date: ____/____/____

First Name: _____ MI: _____ Last Name: _____

Address: _____ Apt/Lot#:_____ City: _____ State: _____ Zip: _____

Cell #:_____ Alt #:_____

****2 phone numbers are required for registration****

Birth Date: ___/___/____ Social Security Number: _____/____/____ Gender: ☐ Male ☐ Female

Ethnicity (for reporting purposes):

☐African American ☐Caucasian ☐Two or more races
☐Asian ☐Native Hawaiian/Pacific Islander ☐ Other: _____
☐Hispanic/Latino ☐American Indian/Alaskan Native

Primary language: _____

Parent/Guardian Information (Minor patients under the age of 18)

First Name: _____ MI: _____ Last Name: _____

Is the address the same as the patient? ☐ **Yes** ☐ **No** If "NO" please complete the address information below

Address: _____ Apt/Lot#:_____ City: _____ State: _____ Zip: _____

Birth Date: ___/___/____ Social Security Number: _____/____/____ Gender: ☐ Male ☐ Female

Primary Insurance Information

Name of Primary Insurance Carrier: _____

Name of Policy Holder: Last Name: _____ First Name: _____

Policy Number: _____ Group Number: _____

Subscribers DOB: ___/___/____ Subscribers Gender: ☐ Male ☐ Female

Subscriber Relationship to Patient: ☐Self ☐Spouse ☐Parent ☐Legal Guardian ☐Other

Urgent Care Co-pay Amount: $_____

PCP (family doctor) Name/Office: _____

Phone #: _____ Fax #: _____

****Please complete the back of this form****

Secondary Insurance Information

Name of Secondary Insurance Carrier: _____

Name of Policy Holder: Last Name: _____ First Name: _____

Policy Number: _____ Group Number: _____

Subscribers DOB: ___/___/____ Subscribers Gender: ☐ Male ☐ Female

Subscriber Relationship to Patient: ☐Self ☐Spouse ☐Parent ☐Legal Guardian ☐Other

Urgent Care Co-pay Amount: $_____

Additional Information

Emergency Contact Name: _____

Phone #:_____ Relationship: _____

How did you hear about us?

☐Family / friend	☐Drive by/sign	☐Internet/web
☐Phone book	☐Mail	☐Newspaper
☐Established patient	☐Insurance Co.	☐PCP
☐Other: _____		

Reason for today's visit: _____

By signing below, I _____ acknowledge that the information I have provided on this form is true and accurate and that I may be held financially responsible for any missing, incorrect, or invalid information associated with this patient and the services rendered at our facilities.

Patient /Parent signature: _____ Date: _____

FD initials: _____