ADULT & PEDIATRIC URGENT CARE
PATIENT REGISTRATION

Date_____ Chart#_____

PATIENT'S NAME_____Birth Date_____Age_____

Parent/Guardian (if under 18)_____ Sex: M F Email : _____

Street Address_____ Mailing Address_____

City_____State_____Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

Social Security # _____

Driver's License #_____ Marital Status M S D W

Patient's Employer_____Occupation_____

Employer's Address_____Work Phone_____

Emergency Contact Information:

Name:_____Relationship to patient:_____

Phone number:_____

Is this a **work related injury**? Yes No If Yes, is a first report on file? Yes No Date of Injury_____

Employer_____ Employer's Phone number_____

Worker's Comp Insurance Name_____Claim #_____

Worker's Comp Address_____Adjuster's Name_____

Is this an injury from a **motor vehicle accident**? Yes No If yes, Date of Injury_____

(Please be aware that Adult & Pediatric Urgent Care will not bill any third party insurances related to a Motor Vehicle Accident)

How were you referred? _____Your Primary Doctor/Family Physician _____

Reason for visit: _____

INSURANCE INFORMATION Circle <u>all</u> methods of payment that apply.

Private/PPO Insurance
Medicare
Worker's Comp Insurance (see above)
Self Pay

PRIMARY INSURANCE	**SECONDARY INSURANCE**
Name_____	Name_____
Member ID#_____	Member ID#_____
Group#_____	Group#_____
Subscriber's Name_____	Subscriber's Name_____
Subscriber's Date of Birth_____ Sex: Male/Female	Subscriber's Date of Birth_____ Sex: Male/Female
Relationship to Patient_____	Relationship to Patient_____

ASSIGNMENT AND MEDICAL RECORDS RELEASE

I hereby assign directly to ADULT & PEDIATRIC URGENT CARE all medical benefits, if any, otherwise payable to me for services rendered by them. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize ADULT & PEDIATRIC URGENT CARE to release all medical and billing information necessary to secure the payment of benefits to my insurer(s) and to my other treating physician(s) I authorize the use of this signature on all my insurance forms.

Signature of Patient/Insured_____Date_____