WiseCare Urgent Care

PATIENT REGISTRATION

How did you hear about WiseCare Urgent Care

___Friend/Relative ___Building Sign ___Mailer ___Internet (Google, Bing, Yelp) ___Website ___TV Ad ___ Physician

_____Social Media _____Movie Theater Ad _____PCP office _____Other clinics _____Other Companies

Name of referral or other: _____

Today's Date: _____

Patient Last Name: _____ First Name: _____ MI:_____

DOB: _____ Age: _____ Gender (Circle One): M F SSN: _____

Race: _____ Ethnicity: _____ Preferred Language: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone Number (Home):_____ Cell Phone: _____ Alt.Number_____

May we leave a message?: ____Yes ____No E-mail: _____

Patient's Employer:_____ Phone Number:_____

Employer Address:_____

Reason for Visit: _____

☐ OCC MED ☐ WORK COMP ☐ MVA Profile Photo on Chart? ☐ Yes ☐ No _____(Initial)

Primary Care Physician_____ Phone Number: _____

PCP Address: _____

Pharmacy Name/Address: _____

EMERGENCY CONTACT:

Name: _____ Relationship: _____ Cell #: _____

Street Address: _____ City_____ State_____ Zip _____

E-mail:_____ Home or Alternate Phone Number:_____

Name: _____ Relationship: _____ Cell #_____

Street Address: _____ City: _____ State: _____ Zip: _____

E-mail:_____ Home or Alternate Phone Number: _____

Patient Name:_____

INSURANCE INFORMATION

Primary Insurance:

Company: _____ Plan: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____

Insurance ID #: _____ Group #: _____

Effectivity Date: _____ Term. Date: _____

Policy Holder's Name: _____ _____ DOB: _____

Relationship to Patient: _____ Gender: ____Male ____Female SSN: _____

Policy Holder's Address: _____

Home Number: _____ Cell #: _____ Alternate Number:_____

Policy Holder's Employer: _____ Phone#: _____

Employer's Address:_____

SECONDARY INSURANCE:

Company: _____ Plan: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____

Insurance ID #: _____ Group #: _____

Effectivity Date: _____ Term. Date: _____

Policy Holder's Name: _____ DOB: _____

Relationship to Patient: _____ Gender: ____Male ____Female SSN: _____

Policy Holder's Address: _____

Home Number: _____ Cell #: _____ Alternate Number:_____

Policy Holder's Employer: _____ Phone#: _____

Employer's Address:_____