Urgent Care Center

PATIENT REGISTRATION FORM

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

Date of Birth: _____ *Social Security #:* _____ *Gender (circle one) Male / Female*

Email: _____ *Home Phone:* _____ *Cell:* _____

Mailing Address: _____ *City:* _____ *State:* _____ *Zip:* _____

Physical Address: _____ *City:* _____ *State:* _____ *Zip:* _____

Employer: _____ *Work Phone:* _____ *Position:* _____

Emergency Contact: Name: _____ *Phone:* _____ *Relationship:* _____

Guarantor/Responsible Party (If patient is under 18)

Last Name: _____ *First:* _____ *MI:* _____ *DOB:* _____

Relationship to Patient: _____ *Gender (circle one) M / F* *Social Security#:* _____

Mailing Address: _____ *City:* _____ *State:* _____ *Zip:* _____

Employer: _____ *Work Phone:* _____ *Cell:* _____

Primary Insurance Information

PRIMARY Insurance Company Name: _____

Patient Insurance Identification #: _____ *Group#:* _____

Name of Insured: _____ *Relationship to patient:* _____

Insured DOB: _____ *Address:* _____ *City:* _____ *State:* _____ *Zip:* _____

Secondary Insurance Information

Secondary Insurance Company Name: _____

Patient Insurance Identification #: _____ *Group#:* _____

Name of Insured: _____ *Relationship to patient:* _____

Insured DOB: _____ *Address:* _____ *City:* _____ *State:* _____ *Zip:* _____

Consent for service and/or disclosure of Protested Health Information

I hereby consent to medical evaluation, testing and/or treatment provided to me by the staff of Dr. Jon's Urgent Care Center, PC. I also understand that Dr. Jon's Urgent Care Center, PC. may disclose my protected health information (PHI) necessary to carry out treatment, payment or healthcare operations. I authorize the release of any information concerning my (or my child/children's healthcare, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I also hereby authorize payment for insurance benefits, otherwise payable to me directly to the doctor and agree to pay any remaining balance once my insurance plan has processed my claim.

_____ _____

Signature of Patient (or parent/guardian of minor) Date: