Family Urgent Care

Medical care for the whole family

Patient Registration/Demographic Form

Date : .....

General

Patient Name : .....
(LAST) (FIRST) (MI)

Address : .....City : .....State : .....Zip : .....

SSN : .....Birth Date : .....Gender: M F Marital Status: M S D W

Home Phone : ..... Cell Phone : .....E-mail : .....

Employer Name : ..... Work Phone : .....

Primary Care Physician Name : ..... Dr. Phone : .....

Emergency Contact Person

Name : ..... Relationship : .....Phone : .....

Guarantor Information (if other than patient)

Name : ..... Address : .....

Relationship to patient : ..... SSN : ..... Birth Date : .....

Pharmacy (if applicable)

Name : ..... Phone: ..... Zip:.....

How did you hear about us?

☐ Family/Friend ☐ Website ☐ Search Engine ☐ Postcard ☐ Facebook ☐ Other

Notice of Privacy Protection

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law and outlying my rights regarding my health information. Initial .....

"I hereby authorize payment directly to Family Urgent Care of all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not covered by insurance for services rendered on my behalf or my dependents. I authorized the above providers to release any information required to secure payment of benefits. I authorize the use of this signature on all insurance submissions."

Signature of Responsible Party ..... Date .....