

PATIENT REGISTRATION

Patient Name (Last): _____ First: _____ int. _____

Address: _____ Apt. #: _____ City, State, Zip: _____

Home #: _____ Cell #: _____ Work #: _____ Message #: _____

Date of Birth: _____ Marital Status: M S D W

Patient Social Security #: _____ - _____ - _____ Sex: M F

Primary Care Physician: _____

Policy Holder Name: _____ Relationship to patient: _____

Primary Insurance: _____ Secondary Insurance: _____

Responsible Party (guardian) Social Security #: _____ Date of Birth: _____

Responsible Party Address: _____ Apt. #: _____ City, State, Zip: _____

Responsible Party Home #: _____ Cell #: _____ Work #: _____

EMERGENCY CONTACT: _____ PHONE #: _____

Where did you hear about Urgent Care Associates? _____

Were you injured on the job? Yes No Date of Injury: _____

I understand and agree that I am obligating myself to pay my account based upon the regular rates of Urgent Care Associates for services provided at Urgent Care Associates.

- In the event I am entitled to medical benefit of any type, those benefits are assigned to Urgent Care Associates for application to my bill.
- Patients eligible for Medicare authorize Urgent Care Associates to bill and collect from Medicare directly.
- **Urgent Care Associates may not be contracted with my insurance company. If this is the case, Urgent Care Associates will bill my insurance for me, but I will be responsible for any charges not covered my health insurance/Medicare, including copayments, deductibles and coinsurance.**
- I also understand that the charges listed are an estimate of the actual costs incurred.

I give permission to release my medical information to _____ and discuss my medical information.

I have read the above Agreements and fully understand.

SIGNATURE _____ RELATIONSHIP TO PATIENT _____

Today's Date _____ WITNESS _____