Patient Registration Form

Your Health is Our Care!

Patient Name: Last _____ First _____ MI _____

Gender: M / F Date of Birth: _____/_____/_____ Social Security #: _____-_____-_____

Address: _____ Apt/Unit #: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____-_____ ok to leave voice message? Y / N

Cell Phone: (____) _____-_____ ok to leave voice message? Y / N

Preferred Language
- ○ English
- ○ Spanish
- ○ Other _____

Race:
- ○ White
- ○ Asian
- ○ African American
- ○ Other _____

Ethnicity
- ○ Hispanic or Latino
- ○ NOT Hispanic or Latino
- ○ Other: _____

Emergency Contact:

_____

Phone: _____

Employer:_____

Phone: _____

Work Status: _____

Confidential Email: _____@_____

Providing your email above will allow use for medical communications & newsletters; we will not distribute to third parties.

PRIMARY Insurance Company: _____

IF NOT SELF:

PRIMARY INSURANCE: Name of Insured: _____ Relationship to Patient: _____

Insured D.O.B: _____/ _____/ _____ Cell Phone: (_____) _____-_____

Address: _____Apt#_____ City _____State____ Zip_____

☐ Check here if you have a SECONDARY INSURANCE

IF PATIENT IS UNDER 18 - RESPONSIBLE PARTY

Last Name: _____ First Name: _____ MI: _____ Gender: M / F D.O.B: ____/____/_____

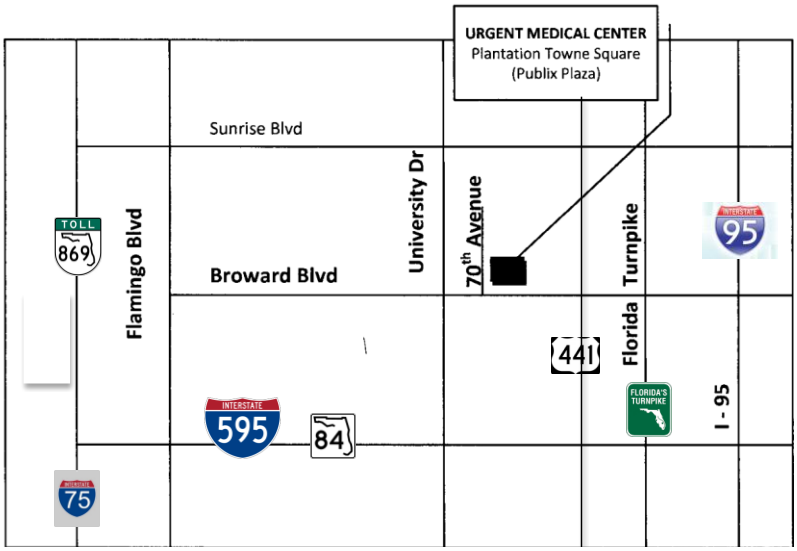
Relationship to patient: _____ Social Security #: _____- ____- _____

Address: _____Apt#_____ City _____State____ Zip_____

Cell Phone: (_____) _____-_____ Home Phone: (_____) _____-_____

Consent for services and/or disclosure of Protected Health Information

I hereby consent to medical evaluations, testing and/or treatment provided to me by the staff of Urgent Medical Center, Inc. I also understand that Urgent Medical Center, Inc may use or disclose any Protected Health Information (PHI) necessary to carry out treatment, payment or healthcare operations. I authorize release of any information concerning me (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of 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. I agree that should my account become delinquent (past 120 days), I will be responsible for all collection costs, including but not limited to the outstanding balance, attorney fees, court costs, collection agency fees and interest at the rate of 18% per annum (1.5% per month).



X _____

Signature of patient or parent/guardian if minor

Date:_____