URGENT CARE OF ERWIN

Patient Registration Form

Is today's visit for a Sport physical or DOT physical? If yes, do not complete this form. See the staff for help.

PATIENT INFORMATION

Name:_____ Preferred Name:_____
(First) (Middle) (Last)

Patient's Sex: ☐ Male ☐ Female Social Security No.: _____-_____-_____ DOB:_____/_____/_____

Street Address:_____ Apt#:_____

City, State, Zip:_____ ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Home Phone: _____ Cell Phone: _____

Email:_____

EMERGENCY CONTACT

Name:_____ Phone: _____ Relationship:_____

GUARANTOR INFORMATION (If the person is under 18 and is not financially responsible, complete this section)

Name:_____ DOB:_____ Phone:_____

Address if different then patient: _____

INSURANCE INFORMATION (Please fill this out as it gives us the legal right to bill your insurance)

Primary Insurance:_____ Policy No.:_____

Policy Holder's Name:_____ Policy Holder's DOB:_____

Secondary Insurance:_____ Policy No.:_____

Policy Holder's Name:_____ Policy Holder's DOB:_____

CONSENT FOR PAYMENT/ TREATMENT

I authorize payment of medical benefits to the undersigned physician. I also authorize the release of any medical or other information necessary to process insurance claims. Upon receipt of my insurance company's Explanation of Benefits (EOB), Urgent Care of Erwin will bill me for any additional amounts indicated and I agree to pay the amounts upon receipt of the statement. I also consent to the care and treatment by the attending physician, his/her associates or assistants and acknowledge that no guarantees have been made as to the effect of such treatment.

Signature:_____ Date:_____

NOTICE OF PRIVACY PRACTICES

I have reviewed the Notice of Privacy Practices as provided at registration and understand that I may request a copy of the policy at any time.

Signature:_____ Date:_____