For office use only:

Date _____ Time in: _____ New____ Est____

Ins Self Pay

PATIENT REGISTRATION
URGENT CARE

PATIENT: Social Security _____

NAME: First _____ Last _____ Middle Init _____

Date of Birth _____ Sex M_____ F_____

Address _____ Zip _____ City _____ State _____

Home Phone ( ) _____ Cell Phone ( ) _____

Marital Status _____ Employer Name _____

Employer Address _____ Zip _____ City _____

State _____ Work Phone ( ) _____ Primary Care Physician _____

WHERE TO SEND THE BILL: (Responsible Party/Parent or Guardian)

NAME: First _____ Last _____ Middle Init ____

Address _____ Zip _____ City _____ State ____

Social Security _____ Date of Birth _____ M ___ F ___

Relationship to Patient _____

Home Phone ( ) _____ Cell Phone ( ) _____

Employer _____ Employer Address _____

Zip _____ City _____ State ____ Emp Phone ( ) _____

INSURANCE: Plan _____

Insurance Claim Address _____

Subscriber Name: First _____ Last _____ Middle Init ____

Social Security _____ Date of Birth _____ M ___ F ___

Relationship to Patient _____

Policy ID _____ Group _____ Effective Date _____

Subscriber Employer _____ Phone ( ) _____

Subscriber Employer Address _____

Zip _____ City _____ State _____

WHERE DID YOU HEAR ABOUT PROMPTCARE?

_____ Been here before	_____ Phone book	_____ Relative
_____ Clinic sign	_____ Work	_____ Friend
_____ Newspaper	_____ Insurance	_____ Doctor referral
_____ Mailer	_____ Internet	_____ Other