# PATIENT REGISTRATION URGENT CARE

Date: ____________________________

Name: First ______________________ Last __________________________ Middle Init _____

Date of Birth ________________ Sex M____ F____ Social Security ______________________

Address _____________________________ Zip ________ City _______________ State _____

Home Phone ( ) __________________ Cell Phone ( ) ________________________

Marital Status ________________ Employer Name ____________________________________

Emp. Address __________________________ Zip _______ City _______________ State _____

Work Phone ( ) __________ Primary Care Physician ___________________

**WHERE TO SEND THE BILL: (If different from above) or circle: SAME**

Name of parent/responsible party if under 18: ________________________________________

Address _________________________________ Zip _______ City _____________ State ____

Social Security ____________________________ Date of Birth ______________ M ___ F ___

Relationship to Patient ______________________________________________________________

Employer ________________________ Employer Address ______________________________

Zip ___________ City ____________________ State ____ Emp Phone ( ) _____________

**INSURANCE COMPANY:**_______________________________________________________

Policy ID ______________________________ Group ______________ Effective Date ______

Insurance Claim Address ______________________________________________________________

Subscriber Relationship to Patient: _______________________ or circle: SELF

Subscriber Info if not self: First Name ____________________ Last ____________________

Social Security ________________________________ Date of Birth ___________ M ___ F ___

Subscriber Employer __________________________________ Phone ( ) _____________

Subscriber Employer Address ______________________________________________________

Zip _________ City ____________________________ State _____

**WHERE DID YOU HEAR ABOUT PROMPTCARE?**

_____ Been here before _____ Radio _____ Relative

_____ Clinic sign _____ Work _____ Friend

_____ Newspaper _____ Television _____ Doctor referral

_____ Mailer _____ Internet _____ Other