Express Urgent Care Patient Registration Form

How did you hear about us? _____ What's the reason for your visit today? _____

Patient Information

Name ☐ Male ☐ Female
SS# DOB
Street Address Apt#
City, State. Zip
*Confidential Phone
*Confidential Email

Primary Care Physician
PCP Address
PCP Phone
Preferred Pharmacy
Best Form of Contact ☐ Cell ☐ Home ☐ Email ☐ Mail
Best Time to Call May we leave a message? ☐ Yes ☐ No

In order for us to service your account or to collect any amounts owed to us, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers which may result in additional charges from your phone carrier. We may also contact you by sending text messages or emails, using all email addresses that you have provided. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

By initialing, I acknowledge that I have read this disclosure and agree that you may contact me as described above. _____

Based on government regulations, we're required to ask the following:

☐ Hispanic or Latino
☐ Non-Hispanic or Non-Latino
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Caucasian
☐ Native Hawaiian
☐ I prefer not to answer

Emergency Contact

Name
Street Address Apt#
City, State. Zip

Relationship
Home Phone
Cell Phone

Financial Responsibility

☐ Check if same as patient information. If not, please complete the entire section.

Name ☐ Male ☐ Female
SS# DOB

Relationship
Phone

I acknowledge full financial responsibility to any services received and I understand that the payment of charges incurred within this office is due at the time of service. I also understand that the charges not covered by insurance remain in my responsibility and assign endurance benefits to this office. In the event that my account is turned over to a collection agency, I agree to pay all late fees, costs of collection fees and/or Attorney's fees and all court costs, if any.

_____ _____
Signature Date

Insurance Information

☐ Check if same as patient information. If not, please complete the entire section.

Primary Insurance
Plan
Subscriber Name
DOB Relationship

Secondary Insurance
Plan
Subscriber Name
DOB Relationship

Consent for Treatment

I understand, 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.

_____ _____
Parent/Guardian Signature (if patient is a minor) Date

Notice of Privacy Practices

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

_____ _____
Parent/Guardian Signature (if patient is a minor) Date

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