PATIENT REGISTRATION FORM

(Please Print)

Today's date:	**Reason for your visit:** **Is this injury resulting from work or motor vehicle accident?** ☐ Yes ☐ No

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	City, State	ZIP Code:

Social Security no.	Home phone no.: ( )	Cell phone no.: ( )	Email:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to by (please check one box): ❑ Internet _____ ❑ Insurance Plan

❑ Family/Friend ❑ Advertisement ❑ Close to home/work ❑ Yellow Pages ❑ Other

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Name of Insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Address (if different):

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

PRIMARY CARE PHYSICIAN INFORMATION

Primary Care Physician Name:

PCP's Location/Phone:

PREFERRED PHARMACY
Pharmacy Name:
Location (cross streets):

NOTICE OF PRIVACY PRACTICES	
See office file, copies of this form will be made available upon request.	
I hereby acknowledge that I have received and read a copy of Signature Urgent Care's HIPPA: Notice of Privacy Practices.	
Patient/Guardian signature	***Date***

GUARANTEE OF PAYMENT AND ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment directly to Signature Urgent Care for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

Fees incurred in Collection or Litigation of any unpaid balances will become the responsibility of the patient or guarantor. I irrevocably assign my benefits to Signature Urgent Care including the right to sue my insurance company for denials or reductions. I also agree that if a referral is needed by my primary doctor, it is my responsibility to obtain it. I authorize the above medical provider to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

The above information is true to the best of my knowledge.

Patient/Guardian signature	***Date***