



PATIENT REGISTRATION

PATIENT INFORMATION:

Name: _____
 Date of Birth: _____ SSN #: _____
 Street Address: _____
 City: _____ State: _____ Zip: _____
 Home #: _____ Cell #: _____
 E-mail: _____ Sex: M / F

PATIENT EMPLOYMENT:

Employer Name: _____
 Employer Phone: _____ Extn: _____

EMERGENCY CONTACT:

Name: _____
 Phone #: _____

BEST FORM OF CONTACT:

- Home # Cell#
 Work# Other #

Best Time to Call: _____

Ok to Leave Message? Yes No

GUARANTOR INFORMATION (Information of person financially responsible for patient)

Check if same as above patient; if not please fill out the following:

Name: _____
 Date of Birth: _____ SSN #: _____
 Street Address: _____
 City: _____ State: _____ Zip: _____
 Home #: _____ Cell #: _____
 E-mail: _____ Sex: M / F

Relationship to Patient: Spouse Child Other

Guarantor Employer: _____
 Employer Phone: _____ Ext: _____

ASSIGNMENT OF BENEFITS AND GUARANTEE OF ACCOUNT:

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

X _____ Date: _____
 Patient/Guarantor Signature

INSURANCE INFORMATION:

Copy of cards on file

PRIMARY INSURANCE

Insurance Plan Name: _____
 Policy ID #: _____ Group #: _____

Relationship to Insured Self Spouse Child

Subscriber Name: _____
 Subscriber Date of Birth: _____

SECONDARY INSURANCE (if applicable)

Insurance Plan Name: _____
 Policy ID #: _____ Group #: _____

Relationship to Patient: Self Spouse Child Other

Subscriber Name: _____
 Subscriber Date of Birth: _____

HOW DID YOU HEAR ABOUT US?

<Please Circle One>

Family/Friends (please name) _____ Internet _____ Healthcare Provider _____ Location _____ Other _____

AUTHORIZATION:

By providing this authorization I understand that the authorization is **voluntary** and is being done at the request of the patient. I understand that I may refuse to sign this authorization section and my treatment and/or payment obligations will not be affected. I understand that I may revoke this authorization by notifying Urgent Care by the bay, in writing, but if I do, it will not have any effect on disclosures or uses prior to receipt of revocation. This authorization will stand effective for six years or until I specifies otherwise.

I hereby authorize Urgent Care by the bay to use, disclose health information as follows:

Name: _____ Relationship: _____
 Name: _____ Relationship: _____

CONSENT FOR TREATMENT: I, the undersigned, consent to the evaluation, testing and treatment by the Urgent Care by the bay attending physician, his/her associates and/or assistants.

Signature: X

Date: _____

<Patient signature if patient over age 13>