PATIENT REGISTRATION

PATIENT INFORMATION:

Name: _____

Date of Birth: _____ SSN #: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____

E-mail: _____ Sex: M / F

BEST FORM OF CONTACT:

Primary Care Physician _____

Preferred Pharmacy _____

PATIENT EMPLOYMENT:

Employer Name: _____

Employer Phone: _____ Extn: _____

EMERGENCY CONTACT:

Name: _____

Phone #: _____

Relationship: _____

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: _____ Relationship to Patient: Spouse Child Other

Date of Birth: _____ SSN #: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____

E-mail: _____ Sex: M / F

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:

O Copy of cards on file

PRIMARY INSURANCE

Relationship to Insured Self Spouse Child

Insurance Plan Name: _____

Policy ID #: _____ Group #: _____

Subscriber Name: _____

Subscriber Date of Birth: _____

SECONDARY INSURANCE (if applicable)

Relationship to Patient: Self Spouse Child Other

Insurance Plan Name: _____

Policy ID # _____ Group #:

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 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>