

# Patient Registration Form



Date:					
Patient Demographics					
Social Security Number:	First Name	Last Name		M Initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss
Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Address		City	State      Zip Code
Home Phone		Cellphone	E-Mail		Primary Care Physician
Emergency Contact Name (Last, First)			Relationship		Emergency Contact Telephone
Race:		Are you Hispanic or Latino?		Preferred Language	
Preferred Pharmacy		How did you hear about us? <input type="checkbox"/> Friend <input type="checkbox"/> Insurance Directory <input type="checkbox"/> Physician (Please list physician's name) _____ <input type="checkbox"/> Internet <input type="checkbox"/> Signage <input type="checkbox"/> Work <input type="checkbox"/> Community Event <input type="checkbox"/> Other: _____			
Insurance Information					
Primary Insurance Company		ID/Policy Number	Group Number	Patient's Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
Subscriber's Last Name, First Name, Initial		Subscriber's Social Security Number			
(If Applicable) Secondary Insurance Company		ID/Policy Number	Group Number	Patient's Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
Subscriber's Last Name, First Name, Initial		Subscriber's Social Security Number			
Work Comp/Auto Accident Information (If Applicable)					
Date of Injury	<input type="checkbox"/> Work Related Injury <input type="checkbox"/> Auto Accident	Employer Name		Employer Telephone	Occupation
Insurance Company		Insurance Company Address	City		State      Zip Code
Insurance Telephone		Adjuster Name	Claim Number		Date of Injury

I, the undersigned, certify that I (or my dependent) have insurance coverage as indicated above and assign directly to Integrity Urgent Care all insurance benefits, if any, otherwise payable to me for services rendered. I grant permission to Integrity Urgent Care to perform routine outpatient clinical care. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the practice to release all information necessary to secure the payment of benefits or to my primary care physician if needed. I authorize the use of this signature on all insurance submissions. **I understand that my co-pay is due at the time of service.**

I also acknowledge that I have been offered a copy of the Notice of Privacy Practices for the practice of Integrity Urgent Care.

\_\_\_\_\_  
**Patient/Responsible Party Signature**

\_\_\_\_\_  
**Date**