



Urgent Care Walk-In Medical Centers

For Toll Free 1-888-636-6991  
Web Registration

<b>For Internal Use Only:</b>		New Patient <input type="checkbox"/>	Estab.Patient <input type="checkbox"/>
Chief Complaint		Payment Collected	
5 Points		Insurance Verification	
Demographics		Discharged	
Consent Signed		Scanned	

## PATIENT REGISTRATION F O R M

**DATE** \_\_\_\_\_

### REASON FOR TODAY'S VISIT

Chief Complaint/Symptoms: _____	Referred by Doctor: _____
<input type="checkbox"/> <b>Medical Treatment (list symptoms above)</b> <input type="checkbox"/> <b>Work Related Injury – Worker's Compensation</b> <input type="checkbox"/> <b>Car Accident</b> <input type="checkbox"/> <b>Pre-op Medical Clearance</b>	<b>Physicals:</b> <input type="checkbox"/> <b>School, Work Physical, DOT physical</b> <input type="checkbox"/> <b>FAA Physical, Travel Physical</b> <input type="checkbox"/> <b>Immigration Physical</b>

### PATIENT INFORMATION

Last Name:		<b>Date of Birth:</b>	Month	Day	Year
First Name:	Middle Initial:	<b>Sex:</b>	<input type="checkbox"/> MALE	<b>Marital Status:</b>	
		<input type="checkbox"/> FEMALE	<input type="checkbox"/> Single	<input type="checkbox"/> Widowed	<input type="checkbox"/> Separated
			<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Partner
Mailing Address:	Apt/ Unit #:	<b>Social Security:</b> _____ - _____ - _____			
City:	<b>Employer:</b> _____				
State:	Zip Code:	<b>Employment Status:</b>			
		<input type="checkbox"/> Full Time	<input type="checkbox"/> Retired	<input type="checkbox"/> Student	
		<input type="checkbox"/> Part Time	<input type="checkbox"/> Self Employed	<input type="checkbox"/> Not Employed	
Home Phone: ( ) -	Cell Phone: ( ) -	<b>Race:</b>		<b>Preferred Language:</b>	<b>Ethnicity:</b>
okay to leave voice message? <input type="checkbox"/> YES <input type="checkbox"/> NO	okay to leave voice message? <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> White	<input type="checkbox"/> _____	<input type="checkbox"/> English	<input type="checkbox"/> Hispanic or Latin
		<input type="checkbox"/> Asian	Other	<input type="checkbox"/> Spanish	<input type="checkbox"/> <b>Not</b> Hispanic or Latin
		<input type="checkbox"/> African American		<input type="checkbox"/> Other _____	
Work Phone: ( ) -	<b>Preferred Pharmacy:</b> _____		<b>Email:</b> _____		
Extension:	<b>Phone:</b> _____		<small>Noting your email above will allow use for medical communications &amp; newsletter; It will not be distributed to third parties. You may elect to remove at any time.</small>		
	<b>Address:</b> _____				

### PRIMARY INSURANCE COMPANY / RESPONSIBLE PARTY

Insurance Company: _____				
Name of Policy Holder/Responsible Party:	<b>Policy Holder's Date of Birth:</b>	Month	Day	Year
Policy Holder's Social Security: _____	Policy Holder's Relationship to Patient: _____			
Subscriber Number: _____	Group Number: _____			
Check here if <b>Secondary Insurance</b> applies: <input type="checkbox"/>	Secondary Name: _____			

### EMERGENCY CONTACT INFORMATION

Contact Person: _____	Phone Number: _____	Relationship to Patient: _____
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