Priority Urgent Care
REGISTRATION FORM

Today's Date: PCP:

PATIENT INFORMATION

Patient's last name: Middle: Last:

Birth date: Age: Sex: M/F Marital Status:

Address:

Social Security no.: Home phone: Cell phone:

Occupation: Employer: Phone no.:

How did you hear about us? Friend/Relative : Signage : Internet/Website : Other :

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: Birth date:
SSN:

Address (if different): Home phone no.:

Occupation: Employer:

Employer address: Employer phone no.:

Please indicate primary insurance:

Subscriber's name: Subscriber's S.S. no.:
Birth date:

Group no.: Policy no.: Co-pay:

Patient's relationship to subscriber:

Name of secondary insurance (if applicable):

Subscriber's name: SSN:

Group no.: Policy no.:

Patient's relationship to subscriber:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):

Relationship:

Home phone no.: Work phone no.:

CONSENT FOR SERVICES AND DISCLOSURE OF PHI:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance.I hereby consent to medical evaluations,testing and or treatment provided to me by the staff of Priority Urgent Care.I also understand that Priority Urgent Care may use or disclose any Protected Health Information (PHI) necessary to carry out treatment, payment or healthcare operations.I authorize release of any information concerning me (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits, otherwise payable to me,directly to the doctor and agree to pay any remaining balance once my Insurance Plan has processed my claims

Patient/Guardian signature Date