AccuDoc Urgent Care

Registration Form

Please Fill Out Form Completely

PLEASE PRINT **TODAY'S DATE:**

PATIENT INFORMATION

PATIENT'S NAME:
LAST: **FIRST :** **MIDDLE:**

MR. MRS.
MISS MS

MARITAL STATUS:
SINGLE MARRIED SEPARATED WIDOW

FORMER NAME:

BIRTH DATE:

AGE:

SEX:
MALE
FEMALE

STREET ADDRESS:

CITY:

STATE:

ZIP CODE:

P.O. BOX:

SOCIAL SECURITY NUMBER:

PHONE NUMBERS:
PRIMARY #:
CELL #:

EMAIL:

PRIMARY PHYSICIAN/PHONE:

ACCIDENT: CIRCLE ONE
YES **NO**

DATE OF ACCIDENT: **STATE OF ACCIDENT:** **CIRCLE:** **EMPLOYER NAME/ADDRESS/PHONE: (IF WORK RELATED)**

WORK **AUTO** **OTHER**

PREFERRED PHARMACY:

CVS **MEDICINE SHOPPE**
WALGREENS **GEORGE'S**
WAL-MART **NOLTES**
KROGER **OTHER:_____**

HOW DID YOU HEAR ABOUT US?

DOCTOR REFERRAL **EXISTING PATIENT**
FRIEND **INSURANCE DIRECTORY**
INTERNET **MAILER**
NEWSPAPER **PHONE BOOK**
RADIO **RELATIVE**
SIGNAGE **TELEVISION**
WORK

RACE:
WHITE
AMERICAN INDIAN
ALASKA NATIVE
ASIAN
BLACK
AFRICAN AMERICAN
NATIVE HAWAIIAN
SPECIFIC ISLANDER

ETHNICITY:

HISPANIC OR LATINO
NON HISPANIC
PATIENT DECLINES

INSURANCE INFORMATION

PLEASE GIVE YOUR INSURANCE CARD & PHOTO ID TO THE RECEPTIONIST

PERSON RESPONSIBLE FOR THE BILL:

BIRTH DATE:

RESPONSIBLE PARTY'S SOCIAL SECURITY NUMBER:

PHONE NUMBER:

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE PHYSICIAN. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY REMAINING BALANCE. I ALSO AUTHORIZE ACCUDOC URGENT CARE OR THE INSURANCE COMPANY TO RELEASE ANY INFORMATION REQUIRED TO PROCESS MY CLAIMS.

RESPONSIBLE PARTY'S SIGNATURE: _____ DATE: _____