Patient Registration Form

Integrity URGENT CARE

Date:

Patient Demographics					
Social Security Number:	First Name	Last Name	M Initial	☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss	
Date of Birth	Sex ☐ Male ☐ 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? ☐ Friend ☐ Insurance Directory ☐ Physician (Please list physician's name)_____ ☐ Internet ☐ Signage ☐ Work ☐ Community Event ☐ Other:_____				

Insurance Information			
Primary Insurance Company	ID/Policy Number	Group Number	Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other
Subscriber's Last Name, First Name, Initial	Subscriber's Social Security Number	Subscriber's Date of Birth	
(If Applicable)Secondary Insurance Company	ID/Policy Number	Group Number	Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other
Subscriber's Last Name, First Name, Initial	Subscriber's Social Security Number	Subscriber's Date of Birth	

Work Comp/Auto Accident Information (If Applicable)					
Date of Injury	☐ Work Related Injury ☐ 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.

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Patient/Responsible Party Signature **Date**

Revised 11/07/2018