MidAtlantic Urgent Care CLARENDON

Patient Registration Form

Patient Name: Last ______________________________ First ________________________ MI ___
______ DOB: ___________________
Social Security #: ________ - _________ - _________ Gender: M / F Home Ph:()__________Cell Ph: (__)___
____
Physical Address: ____ City: ____________________
______ State: ______ Zip: __________
Reason for Today's Visit:___________________________ Have you been here in the past year? Yes ___
N___
Is this related to a **Work Accident**? Yes___No___ **Auto Accident**? Yes___No___**Other Accident**? Yes___No_____
Employer: ___________________________________ Phone: (__)________________ Employer
Contact______________________
Employer Address:_______________________________ Primary Care Doctor__________________
Emergency Contact: Name _____________________________ Phone: (_____)____________
Relationship:_______________
How did you hear about us?______________________ Email:__________ _______________

Guarantor/ Responsible Party (if patient is under 18)

Last Name: ______________________________ First Name: ________________________ MI: ___
______ DOB:_____________________
Relationship to patient: _______________________ Gender (circle one): M / F Social Security #: ____
______ - __________ - _________
Employer: ___________________________ Home: (____)______________Cell: (_)__________
______Other: (__________)_____________________
Address: _____________________________________ City: ________________________ State:
__________ Zip:_______________

Insurance Coverage

PRIMARY Insurance Company:____
Insurance Policy #: ______________________________ Group #: ____________________
____
Claim Mailing Address: ___________________________________ Suite: ___________________
____
City: ____State: ____________________
______ Zip: ________________________
Name of Insured: ____ Relationship to Patient: ____
____
Insured DOB: _____________________ **Insured Social Security #:** _________ - _________ - _________
Phone: (_____)____________________

Address: ____ City: ______________________
State: __________ Zip: __________
SECONDARY Insurance Company: ____
____
Insurance Policy #: ____ Group #: ___
____

Claim Mailing Address: ____
Suite: ______________________________
City: ____ State: ______________
____________ Zip: ____________________
Name of Insured: ____ Relationship to Patient: ________________________
_**Insured** DOB: ____________________ **Insured Social Security #: ________-________-________**
Phone: (_____)____________________
Address: ____ City: ________________________
State: __________ Zip: __________

<u>Consent for services and/or disclosure of Protected Health Information</u>

I hereby consent to medical evaluations, testing and/or treatment provided to me by the staff of Mid Atlantic Urgent Care. I also understand that Mid Atlantic 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 claim.

____

Signature of patient or parent/guardian if minor Date