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