

PROVIDENCE URGENT CARE PATIENT REGISTRATION

Patient Information

Patient Full Name:		
<input type="checkbox"/> New Patient <input type="checkbox"/> Existing Patient		
Reason for Visit:		
Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Social Security #:	Ethnicity/Race:	
Local Address:	Apt #:	
City:	State:	Zip:
Primary Phone #:	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	
Secondary Phone # :	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	
Email Address:	By providing your email address, you consent to our Email Privacy Policy	
How did you hear about us?		
<input type="checkbox"/> Location <input type="checkbox"/> Customer Service <input type="checkbox"/> Email <input type="checkbox"/> Facility Signage <input type="checkbox"/> Family/Friend/Word of Mouth <input type="checkbox"/> Internet/Online Search <input type="checkbox"/> Print Advertising <input type="checkbox"/> Radio <input type="checkbox"/> Phone Book/Yellow Pages <input type="checkbox"/> School/Daycare: _____ <input type="checkbox"/> Employer: _____ <input type="checkbox"/> Community Event: _____ <input type="checkbox"/> Hotel: _____ <input type="checkbox"/> Physician Referral: _____ <input type="checkbox"/> Pharmacy: _____ <input type="checkbox"/> Apartment Complex: _____ <input type="checkbox"/> Insurance: _____		
Marital Status: <input type="checkbox"/> Child <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated		
Spouse's Full Name:		
Permanent Address (other than local):		
City:	State:	Zip:
Primary Care Physician:		
Employer:		

Thank you for choosing Providence Urgent Care. Your satisfaction is important to us! Please leave your email address in the space provided and we will send you a survey about your visit today.

Insurance Subscriber Information

Complete Only if NOT the Patient

Insured Subscriber Full Name:		
Subscriber's Date of Birth:		
Subscriber's Social Security #:		
Subscriber's Relationship to Patient:		
Subscriber's Permanent Address:	Apt #:	
City:	State:	Zip:
Subscriber's Primary Phone #:	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	
Subscriber's Secondary Phone #:	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	
Subscriber's Employer:		

Complete Insurance Details

Insurance Company:		
Type: <input type="checkbox"/> HMO / PPO <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid/AHCCCS <input type="checkbox"/> Tricare <input type="checkbox"/> Other		
ID / Policy #:	Group #:	
Copay/Coins/Ded Amount:	Effective Date:	
Secondary Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No Name:		

Parent/Legal Guardian of Minor or Incapacitated Adult Only

Full Name:	Date of Birth:
Relationship:	Contact #:
Signature	
Patient's Name:	Date:
Signature:	