PATIENT REGISTRATION

LAST Name _______________________________**FIRST** Name________________________ M.I._______

Address: ____ Apt #__________________

City__________________________ State_______ Zip_________________ PO Box____________________

Sex ___ Marital Status (circle) S M D W Date of Birth _____________ Age_____ SS#_________________

Email ____

Home Phone____________________ Cell __________________ Work__________________

Emergency Contact ______________________________Relationship________________Phone___________

Person Responsible for Bill ____Phone____________________

Primary Care Physician____________________________________Phone_____________________________

Referring Physician_______________________________________Phone_____________________________

How did you learn about Physicians Urgent Care?____

Primary Insurance____________________________ Secondary Insurance_____________________________
(Please have insurance card(s) and driver's license ready to be copied.)

*** PHARMACY____** Phone: ___________________________

PAYMENT TERMS: Payment is due at time of service. We accept most insurance and will file your insurance; however, patient is responsible for any unpaid balances or full payment if insurance is denied. Patient is responsible for knowing what your insurance covers, or not, and which labs your insurance is contracted with. We use LabCorp. Please let us know if your insurance uses a different lab. Copays and coinsurances are due at time of service. If self-pay, a deposit may be required prior to service. By signing below, you acknowledge full responsibility for all services provided to you and agree to pay all expenses including collection and attorney fees, if necessary to collect your balance. Your visit constitutes a credit transaction and as such, we, or our agent(s), have permission to report unpaid balances to the credit bureaus and may seek address and employment information as necessary to effect collection of any unpaid balance.

FEDERAL PRIVACY ACT: I have received a copy of the Notice of Privacy Policy, ____yes ____no.
______It is OK to leave messages on my voicemail at home, cell, or work. (Circle all that apply.)
______Do NOT leave a voicemail message on my phone.

*** Y N** ***For best patient care, I authorize* PUC *to download my medication information from my pharmacy.***

Please check how you will make payment(s) today: Cash____ Check____ (There is a $25 fee for returned check.) Insurance_____ Credit/Debit Card_______ Worker's Comp______ (If this is a worker's comp injury, please give your authorization papers to the receptionist.)

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Patient, parent or guardian signature Date