PATIENT REGISTRATION

Reason(s) for your visit today ____

PHARMACY_____________________ Location ______________________ Phone: _________________

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

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#__________________

Person who carries insurance _________________________DOB ________ Phone__________________

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Email _________________________________ Employment ____________________________________

Home Phone_________________________ Cell _______________________ Work__________________

Responsible Party: **LAST** Name_______________________ **FIRST** ______________________________

Address: ____ Apt. # ______________

City: ____________________________________ State: _________________ Zip: __________________

Emergency Contact ____________________________Relationship_______________Phone___________

Primary Care Physician_________________________________Phone___________________________

How did you learn about Physicians Urgent Care? ____

PAYMENT TERMS: Copays and coinsurances are due at time of service. We will run an estimate at the time of service to determine what your insurance will cover and what your responsibility is. You are responsible for any unpaid balances or full payment if insurance is denied. There is a $50 fee for returned checks. 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.

Patient, parent or guardian signature Date

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