

PATIENT REGISTRATION

PATIENT INFORMATION (Please list all names and nicknames) Today's Date: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address: _____ Apt./Suite No. _____ P.O. Box _____

City: _____ State: _____ Zip Code: _____ Home: (____) _____ - _____

Cell: (____) _____ - _____ Facebook name/Twitter Handle _____ **May we, or our authorized agents, leave a message or contact you electronically regarding your care, scheduling, follow-up, and billing?** Yes No Initial _____ **If no, which number may we, or our authorized agents, utilize regarding payment?** (____) _____ - _____

Date of Birth: ____/____/____ Social Security #: _____ Email Address: _____

Sex: Male Female Marital Status: Single Married Divorced Widowed Employment: Full-Time Part-Time Unemployed

Employer Name and Position with company: _____ Phone #: (____) _____ - _____

Emergency Contact Name: _____ Phone #: (____) _____ - _____

Primary Care Physician: _____ Phone #: (____) _____ - _____

If applicable, please list spouse: _____ Phone #: (____) _____ - _____

Is this an on-the-job or WORK-RELATED injury? Yes No If yes, complete the following:

Date of Injury: _____ Worker's Compensation Claim #: _____

Name of Attorney: _____ Phone #: (____) _____ - _____

Is today's visit the result of injuries sustained in a MOTOR VEHICLE ACCIDENT? Yes No If yes, complete the following:

Date of Injury: _____ Insurance Company: _____ Claim #: _____

Name of Attorney: _____ Phone #: (____) _____ - _____

GUARANTOR INFORMATION: (List person **RESPONSIBLE FOR BILL IF OTHER THAN PATIENT** - Please list all names and aliases) - **GUARANTOR MUST BE PRESENT**

If over 18 years of age, please indicate if billing statements should be mailed to responsible party: Yes No Initial _____

Relationship of Guarantor to Patient: Self Spouse Parent Other

Last Name: _____ First Name _____ Middle Initial: _____

Mailing Address: _____ Apt./Suite No. _____

City: _____ State: _____ Zip Code: _____

Home: (____) _____ - _____ Cell: (____) _____ - _____ Work: (____) _____ - _____

Date of Birth: ____/____/____ Social Security #: _____ Email Address: _____

Sex: Male Female Marital Status: Single Married Divorced Widowed

Employer Name, Position, Address _____

INSURANCE INFORMATION: MUST PROVIDE INSURANCE CARDS TO RECEPTIONIST TO PHOTOCOPY

IF SOMEONE OTHER THAN PATIENT IS THE POLICY HOLDER, PLEASE INCLUDE POLICY HOLDER'S DATE OF BIRTH

PRIMARY INSURANCE: _____ Policy ID #: _____ Group #: _____

Policy Holder's Name (Last name first): _____ Date of Birth: ____/____/____ Social Security #: _____

SECONDARY INSURANCE: _____ Policy ID #: _____ Group #: _____

Policy Holder's Name (Last name first): _____ Date of Birth: ____/____/____ Social Security #: _____

REFERRAL INFORMATION: Were you referred by a physician? Yes No If yes, Name of Physician and phone # _____

How did you hear about Lakewood Urgent Care? Physician Insurance Company Employer Attorney Friend Website Internet

Drive-by Print Ad Other _____

I certify that the information provided is correct to the best of my knowledge. I will not hold Lakewood Urgent Care, its health providers, or its employees responsible for any errors or omissions that I may have made in completing the information on this form.

Ø _____ Date: _____