QuickCare APRN-CNP, LLC URGENT CARE

Patient Registration

Reason for visit:_____

PATIENT INFORMATION PLEASE PRINT

LAST NAME: _____

FIRST NAME: _____

MIDDLE NAME: _____

PREFERRED NAME: _____

MAILING ADDRESS: _____

CITY: _____STATE: _____

ZIP: _____

HOME PHONE: (_____) _____

CELLPHONE: (_____) _____

WORK PHONE:(_____) _____

CONTACT PREFERENCE:
HOME/ WORK/CELL/E-MAIL/PORTAL/TEXT MESSAGE

SEX: M or F

DATE OF BIRTH: _____/_____/_____

SOCIAL SECURITY NO: _____/_____/_____

PATIENT E-MAIL: _____

LANGUAGE: _____

RACE: _____

ETHNICITY: _____

MARITAL STATUS:(Please Circle One) S M D W

PRIMARY DOCTOR:_____

PREFERRED PHARMACY_____

ALLERGIES: _____

_____

EMERGENCY CONTACT

NAME: _____

RELATIONSHIP: _____

PHONE:(_____) _____

MOBILE PHONE:(_____) _____

GUARANTOR INFORMARTION (TO WHOM STATEMENTS ARE SENT/ IF SELF WRITE SELF)

NAME:_____

ADDRESS:_____

_____

RELATIONSHIP TO PATIENT: _____

DOB: _____/_____/_____

SSN: _____/_____/_____

PHONE NUMBER:(_____)_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY :

ID :_____Group#_____

POLICY HOLDER'S NAME:_____

LAST NAME:_____

ADDRESS:_____

CITY_____ STATE_____

ZIP CODE: _____

POLICY HOLDER DOB:_____/_____/_____

PATIENTS RELATIONSHIP TO POLICY HOLDER_____

SECONDARY INSURANCE COMPANY:

ID:_____Group:_____

POLICY HOLDER'S FIRST NAME:_____

LAST NAME:_____

ADDRESS:_____

CITY_____STATE_____

ZIP CODE:_____

POLICY HOLDER DOB:_____/_____/_____

PATIENTS RELATIONSHIP TO POLICY HOLDER_____

**********PLEASE SIGN BACK PAGE**********

QuickCare APRN-CNP, LLC URGENT CARE

Acknowledgement & Authorization for Care

Please read, sign, and date below.

- I have read and understand the HIPAA/Privacy Policy for QuickCare APRN-CNP, LLC
- I hereby assign my insurance benefits to be paid directly to the healthcare provider.
- I authorize QuickCare APRN-CNP, LLC to release medical information required to process my claim.
- I have read and understand the Financial Policy for QuickCare APRN-CNP, LLC.
- I authorize QuickCare APRN-CNP, LLC to obtain/have access to my medication history.
- I authorize QuickCare APRN-CNP, LLC to contact me by mobile phone
- I understand that I will receive a separate bill from the lab for any labs that are collected at QuickCare APRN-CNP, LLC.

Signature_____ Date_____

- I give permission for you to speak with the following person(s) about treatment received or financial information concerning myself.

_____ Relationship_____

_____ Relationship_____