PATIENT REGISTRATION

Where did you hear about Gardendale Urgent Care?

___ Friend ___Letter ___Mailer ___Newspaper ___Other
___Phone Book ___Radio ___Relative ___Signage ___Work

Patient Last Name: _____

Patient First Name: _____Middle Initial:_____

Social Security Number: _____ Date of Birth: _____

Gender: ❑ Male ❑ Female Race: _____ Ethnicity: _____

Preferred Language: _____

Street Address: _____

City: _____ State: _____ Zip:_____

Home Telephone: _____ Mobile Telephone: _____

Email: _____ Martial Status: _____

Patient Employer: _____

Primary Care Physician: _____

Insurance Co-Pay amount $ _____ Preferred Method of Contact: ❑ Home ❑ Mobile ❑ Email

Insurance Card Holder: _____
Last Name First Name M.I.

Insurance Card Holder Street Address: _____

Holder's City: _____ State: _____ Zip: _____

Guarantor*: _____
Last Name First Name M.I.

Guarantor's Street Address: _____

Guarantor's City: _____ State: _____ Zip: _____

Guarantor's Phone #: _____

Guarantor's Social Security #: _____ Date of Birth: _____

Gender: ❑ Male ❑ Female Relationship to Patient: ❑ Parent ❑ Spouse

Guarantor's Employer Address: _____

* Guarantor is a person or corporation pledging responsibility of payment

I have read and accept the HIPAA Agreement ❑ Yes ❑ No **Notice of Privacy practices** ❑ Yes ❑ No

I consent to treatment for myself or above minor child. I understand that the examination and/or medical treatment I will receive it NOT intended to replace complete medical care by my personal primary care physician. I am aware that I will be responsible for co-payment or full payment at the time of service. Any pre-certification requirement that my insurance company requires is my responsibility to make. Furthermore, I allow Gardendale Urgent Care to release to my insurance company treatment and billing information, as requested, to process my claim. I allow Gardendale Urgent Care to accept assigned payments made by my insurance company on my behalf. I understand that by my lack of payment or if my insurance denies payment, I am responsible for payment in full for services rendered. My failure to pay may result in collection proceedings. In addition, I authorise Gardendale Urgent Care to release to my primary care physician or specialty referral any and all information related to my treatment at this clinic.

_____ _____

Patient Signature or Parent of Minor ***Date***