ACCESS MEDICAL CENTER URGENT CARE PATIENT REGISTRATION

Patient Information

Patient Full Name:

Reason for Visit:

Date of Birth: Gender: □ Male □ Female

Social Security #:

Local Address: Apt #:

City: State: Zip:

Primary Phone #: □ Home □ Cell □ Work

Secondary Phone # : □ Home □ Cell □ Work

Email Address: By providing your email address, you consent to our Privacy Policy

How did you hear about us?: □ Previous Patient □ Word of Mouth □ Facility Signage
□ Internet/Online Search □ Print Advertising □ Radio □ Phone Book/Yellow Pages
□ School/Daycare: _____ □ Employer: _____
□ Community Event: _____ □ Hotel: _____
□ Physician Referral: _____ □ Pharmacy: _____
□ Apartment Complex: _____ □ Insurance: _____
□ INTEGRIS (Access Medical ONLY): □ Employee □ ER □ Physician _____

Primary Care Physician:

Employer:

Permanent Address (other than local):

City: State: Zip:

Marital Status: □ Child □ Single □ Married □ Divorced □ Widowed □ Separated

Spouse's Full Name:

Minors and Incapacitated Adults Only

Guardian's Full Name:

Guardian's Contact #:

Guardian's Relationship to Patient:

Guarantor/Insurance Subscriber Information
Complete Only if Patient is NOT Guarantor

Guarantor Full Name:

Guarantor Date of Birth:

Guarantor Social Security #:

Guarantor Relationship to Patient:

Guarantor Permanent Address: Apt #:

City: State: Zip:

Guarantor Primary Phone #: □ Home □Cell □Work

Guarantor Secondary Phone #: □ Home □ Cell □Work

Guarantor Employer:

Complete Insurance Details Only if Card is NOT Present in Clinic

Insurance Company:

Type: □ HMO / PPO □ Medicare □ Medicaid/AHCCCS □ Tricare □ Other

ID / Policy #: Group #:

Copay Amount: Effective Date:

Secondary Insurance? □ Yes □ No Name: _____

Signature

Patient / Guardian Name:

Signature: Date:

Thank you for choosing Access Medical Center Urgent Care. Your satisfaction is important to us! Please leave your email address in the space provided and we will send you a survey about your visit today.

Updated: 08/26/14