ACCESS MEDICAL CENTER PATIENT REGISTRATION

Patient Information

Patient Full Name:

☐ New Patient ☐ Existing Patient

Reason for Visit:

Date of Birth: Gender: □ Male □ Female

Social Security #: Ethnicity/Race:

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?: □ Existing 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: _____

Primary Care Physician:

Employer:

Permanent Address (other than local):

City: State: Zip:

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

Spouse's Full Name:

Guardian of Minors or Incapacitated Adults Only

Guardian's Full Name:_____

Guardian's Date of Birth:_____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 NextCare 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.

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