

NEXTCARE URGENT CARE PATIENT REGISTRATION

Patient Information

Patient Full Name:		
<input type="checkbox"/> New Patient <input type="checkbox"/> Existing Patient		
Reason for Visit:		
Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Social Security #:	Ethnicity/Race:	
Local Address:	Apt #:	
City:	State:	Zip:
Primary Phone #:	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	
Secondary Phone # :	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	
Email Address:	By providing your email address, you consent to our Privacy Policy	
How did you hear about us?: <input type="checkbox"/> Existing Patient <input type="checkbox"/> Word of Mouth <input type="checkbox"/> Facility Signage <input type="checkbox"/> Internet/Online Search <input type="checkbox"/> Print Advertising <input type="checkbox"/> Radio <input type="checkbox"/> Phone Book/Yellow Pages <input type="checkbox"/> School/Daycare: _____ <input type="checkbox"/> Employer: _____ <input type="checkbox"/> Community Event: _____ <input type="checkbox"/> Hotel: _____ <input type="checkbox"/> Physician Referral: _____ <input type="checkbox"/> Pharmacy: _____ <input type="checkbox"/> Apartment Complex: _____ <input type="checkbox"/> Insurance: _____		
Primary Care Physician:		
Employer:		
Permanent Address (other than local):		
City:	State:	Zip:
Marital Status: <input type="checkbox"/> Child <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> 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 #:	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	
Guarantor Secondary Phone #:	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	
Guarantor Employer:		

Complete Insurance Details Only if Card is NOT Present in Clinic

Insurance Company:	
Type: <input type="checkbox"/> HMO / PPO <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid/AHCCCS <input type="checkbox"/> Tricare <input type="checkbox"/> Other	
ID / Policy #:	Group #:
Copay Amount:	Effective Date:
Secondary Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> 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.