PATIENT REGISTRATION FORM

☐ **New Patient** ☐ **Established Patient**

PATIENT NAME:	**Sex:** □ Male □ Female
Date of Birth:	**Race:**
Social Security # *(optional)*:	**Ethnicity:**
Mailing Address:	Local Address:
Circle One: Apt., Unit, Bldg., Lot, Suite #:	*Circle One:* Apt., Unit, Bldg., Lot, Suite #:
City: State: Zip:	City: State: Zip:
Home Phone #:	Cellular/Mobile Phone #:
Email Address:	

REASON FOR VISIT:

- **Is this a Work Related Injury?** *(circle one):* **Yes** **No**
- **If yes, have you notified or do you plan to notify your Employer?** *(circle one):* **Yes** **No**

How did you hear about us? *(select one):*

□ Customer Service □ Email □ Facility Signage
□ Family/Friend/Word of Mouth □ Phone Book/Yellow Pages □ Location
□ Internet/Online Search: _____ □ Print Advertising: _____ □ Radio: _____
□ School/Daycare:_____ □ Employer: _____
□ Community Event: _____ □ Hotel: _____
□ Physician Referral: _____ □ Pharmacy: _____
□ Apartment Complex: _____ □ Insurance: _____

INSURANCE DETAILS

Primary Insurance Company:	Copay/Coins/Ded Amount:	
ID/Policy #:	Group #:	
Subscriber Name *(if applicable)*:	SSN:	Date of Birth:
Subscriber's Address *(if applicable)*:		Relationship:
Secondary Insurance Company:	ID/Policy #:	Group #:

Parent/Legal Guardian of Minor or Incapacitated Adult ONLY

Name:	Date of Birth:
Relationship:	Contact #:

SIGNATURE

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.