PATIENT REGISTRATION FORM

☐ New Patient ☐ Established Patient

Patient Name:		
Date of Birth:	Gender: □ Male □ Female	
Social Security #:	Ethnicity/Race:	
Local Address:		Apt #:
City:	State:	Zip:
Cellular/Mobile Phone #:		
Home 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)*:		
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.