# PATIENT REGISTRATION FORM

☐ New Patient ☐ Established Patient

| | | | |
|---|---|---|---|
| **PATIENT NAME:** | | | |
| Date of Birth: | | Sex: □ Male □ Female | |
| Social Security #: | | | |
| 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.