Patient Registration Form

Patient Name: (Last, First, MI): ____

Patient's Home Phone Number: _________________Alternate Phone Number (Cell or Work): ____________

E-Mail Address: _______________________________________ Consent to Web Portal: ☐ Y ☐ N

Address: ____ Apt#: _____

City: _________________________ State: ________ Zip: _____________

Date of Birth: __________________ Age: ______ Sex: M ☐ F ☐ SS#: _______________________

Ethnicity: __________________ Race: _______________ Reason for Visit: ____________________________________

Pharmacy Name: _____________________________________ Ph#: ____________________________

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Emergency Contact: ____________________________________ Relationship to Patient: ____________

Address: ____ Phone#: ______________________

Primary Insurance: __________________________ Policy #: __________________________________

Is Patient subscriber? Y ☐ N ☐ Name: ____________________________ DOB: _______________

Secondary: _____________________ Policy#: __________________________________

Is Patient subscriber? Y ☐ N ☐ Name: ____________________________ DOB: _______________

Release of Information:

I hereby give permission to the person (s) listed below to receive information about the care of the above name patient.

Name (s): ____ Relationship to Patient: ______________

Patient Signature: ___________________________ Date: ______________

Print Name: ______________________________

CLERMONT
URGENT CARE