GRAND AVE URGENT CARE

REGISTRATION FORM

PATIENT INFORMATION

DATE:	PRIMARY CARE PROVIDER:		
LAST NAME:	FIRST NAME:		MI:
ADRRESS:		CITY:	STATE:
ZIP:	SSN:	DOB:	SEX:
EMAIL:	PREFFERED PHONE:		PHARMACY:
REASON FOR VISIT:	HIPAA FORMS:		RELEASE AUTH:
PREFFERED LANGUAGE:	RACE:	ETHNICITY:	

Guarantor Information

LAST NAME:	FIRST NAME:	MI
SSN:	DOB:	RELATION TO PATIENT:

INSURED SUBSCRIBER INFORMATION

LAST NAME:	FIRST NAME:		MI:
SSN:	DOB:	RELATION TO PATIENT:	

EMERGENCY CONTACT

LAST NAME:	FIRST NAME:	MI:
ADDRESS:	CITY:	STATE:
ZIP:	EMAIL:	
RELATIONSHIP TO PATIENT:		

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize GRAND AVE URGENT CARE or insurance compnay to release any information required to process my claims.

Sign: _____ **DATE:** _____