GRAND AVE URGENT CARE REGISTRATION FORM

Primary Care Physician: _____

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Mailing Address: _____ City _____ State _____ Zip Code _____

Physical Address: _____ City _____ State _____ Zip Code _____

Social Security No.: _____ Birth Date: _____ Sex: Female___ Male ___

Email: _____ Preferred phone number: _____ Pharmacy: _____

Reason for Visit: _____

Language: _____

Race:

___ American Indian or Alaska Native
____ Asian
____ White
____ Black or African American
____ Native Hawaiian/Other Pacific Islander
____ Other

Ethnicity:

____ Hispanic or Latino
____ Non Hispanic or Latino

GUARANTOR INFORMATION

(Guarantor of Minor under 18 years of age/Person Responsible for billing)

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City _____ State _____ ZIP Code _____

Social Security No.: _____ Birth Date: _____ Relation to Patient: _____ Phone: _____

EMERGENCY CONTACT

Last Name: _____ First: _____ Middle initial: _____

Relationship to Patient: _____ Phone: _____

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 company to release any information required to process my claims.

Patient/Guardian signature _____ Date _____

GRAND AVE URGENT CARE REGISTRATION FORM

Insurance information

PRIMARY INSURED SUBSCRIBER

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City _____ State _____ Zip Code _____

Birth Date: _____ Relation to Patient: _____ Phone: _____

SECONDARY INSURED SUBSCRIBER

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City _____ State _____ Zip Code _____

Birth Date: _____ Relation to Patient: _____ Phone: _____

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 company to release any information required to process my claims.

Patient/Guardian signature _____ Date _____