SOUTHERN IMMEDIATE CARE

Patient Registration Form

Date:___________

Is today's visit work related?

If yes, do not complete this form. Please see the front desk staff for instructions.

Was this the result of a motor vehicle accident? Yes ☐ No ☐

How did you hear about us?

What's the reason for your visit today?

PATIENT INFORMATION

Date of Birth: SS#:

Mailing Address: Apt#:

City: State: Zip:

Home Ph#: Cell Ph#:

*Confidential Phone:

*Confidential Email:

Primary Care Physician (PCP):

PCP Address:

PCP Ph#:

Preferred Pharmacy:

Pharmacy Ph#:

Sexual Orientation:

Gender ID:

Based on government regulations, we are required to ask the following:

What is your preferred language:

EMERGENCY CONTACT INFORMATION

Name:

Relationship:

Home Ph#:

Cell Ph#:

INSURANCE INFORMATION

Primary Ins: Name Ins #:

of Insured: Date of

Birth:

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Secondary Ins: Ins #:

Name of Insured:

Date of Birth:

Relationship to Patient: ☐ ☐ Spouse ☐ Parent ☐

FINANCIAL RESPONSIBILITY/ASSIGNMENT OF BENEFITS

☐ Check if same as patient information. If not, please complete the entire section.

Name: ☐ Male ☐ Female Relationship:

Date of Birth: SS#: Phone #:

I acknowledge full financial responsibility for any services rendered and I understand that the payment of charges incurred in this office are due at the time of service. I also understand that the charges not covered by insurance remain my responsibility and assign insurance benefits to this office. In the event my account is turned over to a collection agency, I agree to pay all costs of collection fees and/or attorney's fees and all court costs if any. I agree to be contacted at any telephone number or email address associated with my account. This includes cellular telephone numbers or other wireless devices. I understand this could result in a charge from my phone or device carrier to me for talk time, SMS messaging/texts or data usage for emails or voice mails. I also understand methods of contact may include pre-recorded /artificial voice messages and/or the use of automatic dialing devices as applicable.

Signature

CONSENT FOR TREATMENT

I, the undersigned, consent to the care and treatment by the attending Physician, his/her associates or assistants and acknowledge that no

guarantees have been made as to the effect of such treatment.

Signature Date

Date

NOTICE OF PRIVACY PRACTICES

I have reviewed the Notice of Privacy Practices as provided at registration and understand that I may request a copy of the policy at any time.

Signature Date

11.16.2020/sk