

# Advanced Urgent Care Patient Registration Form

## **PATIENT INFORMATION**

Today's Date \_\_\_/\_\_\_/\_\_\_

Name \_\_\_\_\_  
*Last First Middle*

Address \_\_\_\_\_  
*City State Zip*

Home Phone \_\_\_-\_\_\_-\_\_\_ Work Phone \_\_\_-\_\_\_-\_\_\_ Cell \_\_\_-\_\_\_-\_\_\_

DOB \_\_\_/\_\_\_/\_\_\_ Age \_\_\_ SS# \_\_\_-\_\_\_-\_\_\_ Sex F / M Marital Status \_\_\_\_\_

## **PARENT OR RESPONSIBLE PARTY (if different from patient)**

Name \_\_\_\_\_  
*Last First Middle*

Address \_\_\_\_\_  
*City State Zip*

Home Phone \_\_\_-\_\_\_-\_\_\_ Work Phone \_\_\_-\_\_\_-\_\_\_ Cell \_\_\_-\_\_\_-\_\_\_

DOB \_\_\_/\_\_\_/\_\_\_ Age \_\_\_ SS# \_\_\_-\_\_\_-\_\_\_ Sex F / M Marital Status \_\_\_\_\_

## **INSURANCE INFORMATION**

**Primary** Insurance Name \_\_\_\_\_ Name of Insured \_\_\_\_\_

Insured DOB \_\_\_/\_\_\_/\_\_\_ Insured's ID# \_\_\_\_\_ Group # \_\_\_\_\_

Employer Name \_\_\_\_\_ Employer address \_\_\_\_\_

Employer Phone \_\_\_-\_\_\_-\_\_\_ Relationship of patient to insured \_\_\_\_\_

**Secondary** Insurance Name \_\_\_\_\_ Name of Insured \_\_\_\_\_

Insured DOB \_\_\_/\_\_\_/\_\_\_ Insured's ID# \_\_\_\_\_ Group# \_\_\_\_\_

Employer Name \_\_\_\_\_ Employer address \_\_\_\_\_

Employer Phone \_\_\_-\_\_\_-\_\_\_ Relationship of patient to insured \_\_\_\_\_

**Pharmacy** Name \_\_\_\_\_ Phone \_\_\_-\_\_\_-\_\_\_

**Emergency** Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_-\_\_\_-\_\_\_

**Referred By** \_\_\_\_\_ **Primary** Physician \_\_\_\_\_ Phone \_\_\_-\_\_\_-\_\_\_

## **PATIENT AND RESPONSIBLE PARTY AUTHORIZATION**

I authorize **Advanced Urgent Care, P.C.** to apply for benefits on my behalf for the covered services rendered and request that payments from the above named insurance company (ies) be made directly to: **Advanced Urgent Care, P.C.** for the treated person named. I certify that the information reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim to the above named agent. I permit a copy of this authorization to be used in place of the original.

IN ALL CASES, PROFESSIONAL FEES ARE THE PATIENT, SPOUSE, GUARDIAN AND/OR PARENTS' RESPONSIBILITY. Finance Charge (no charge if paid in 30 days of billing date) is computed by a "Periodic Rate" of 1 ½ % per month, which is an ANNUAL PERCENTAGE RATE of 18% applied to the previous balance without deducting current payments and/or credits appearing on any given bill. Patient or responsible party (ies) further agree to pay any and all collection fees incurred and legal expenses, including but not limited to a all collection Agency and Attorney fees ( at 33% ), all court related costs, service and filing fees, interrogatory and garnishment fees as well as any interest that may be adjudicated for the collection of past due debts.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_