Patient Registration Form

Patient Name: Last ___________________________ First _______________________ MI ____ DOB: ___________
Address: ____ City: ________________________ State: _____ Zip: ________
Home Phone: (___)___________ Cell Phone: (____)___________ Email: ___________________________
Social Security #: ________ - - ________ Gender: M / F Marital Status: Single ___ Married ___ Divorced ___
Widowed ___
Best Method of Contact: Home Phone ____ Cell Phone ____ Email ____
Race: American Indian ___ Asian ___ Black or African American ___ Native Hawaiian ___ White ___
Ethnicity: Hispanic or Latino ___ Not Hispanic or Latino ___
Reason for Today's Visit:____
Is this related to a Work Accident? Yes___No___ Auto Accident? Yes___No___Other Accident? Yes___No___
Employer: ____ Phone: (____)______________________
Emergency Contact: Name ____________________________ Phone: (____)___________ Relationship:___________
How did you hear about us? Friend/Relative Signage Television Internet/Website Other __________
Primary Care Physician: ____

Guarantor / Responsible Party (if patient is under 18)

Last Name: ___________________________ First Name: _________________________ MI: ________ DOB:________________
Relationship to patient: __________________ Gender (circle one): M / F Social Security #: ________-________-________
Employer: _______________________ Home: (____)____________Cell: (___)____________Other: (____)________________
Address: _________________________________ City: _______________________ State: _________ Zip:________________

Insurance Coverage

PRIMARY Insurance Company:____
Insurance Policy #: ____ Group #: _____________________________________
Insured's Name: ____ Relationship to Patient: _________________
Insured DOB: ____________________________ Insured Social Security #: ______-________-________

SECONDARY Insurance Company: ____
Insurance Policy #: ____ Group #: _______________________________
Insured's Name: ____ Relationship to Patient: __________________
Insured DOB: ____________________________ Insured Social Security **#:** ______-________-________

<u>Consent for services and/or disclosure of Protected Health Information</u>

I hereby consent to medical evaluations, testing and/or treatment provided to me by the staff of New England Urgent Care. I also understand that New England Urgent Care may use or disclose any Protected Health Information (PHI) necessary to carry out treatment, payment or healthcare operations. I authorize release of any information concerning me (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits, otherwise payable to me, directly to the doctor and agree to pay any remaining balance once my Insurance Plan has processed my claim.

____ ______________________________

Signature of patient or parent/guardian if minor Date

Revised 12/8/2016

NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been given the opportunity to review and request a printed copy of the Privacy Practices of New England Urgent Care, LLC (“NEUC”).

I hereby authorize NEUC to disclose my Protected Health Information (PHI) to my Primary Care Physician (PCP) and/or the following people:

Primary Care Physician (PCP): ____

Phone Number: ______________________ **Fax Number:** ______________________

Name: ______________________________ **Relationship:** ______________________

Name: ______________________________ **Relationship:** ______________________

Name: ______________________________ **Relationship:** ______________________

____________________________________ ____________________________________
Print Patient Name **Date**

____
Patient or Representative Signature

Patient or Representative refused or is unable to sign because of ______________________________

____

Witnessed by: ______________________________ Date: __________________________________