PREMIER
URGENT CARE

Patient Registration

Where did you hear about Premier Urgent Care?

_____Friend _____Mailer_____Newspaper_____Phonebook_____Internet_____Radio
_____Relative _____Physician _____Television _____Signage _____Work _____Other

Patient Name: Last_____ First_____M.I._____

Social Security Number:_____DOB:_____

Gender (Circle): Male Female Race:_____ Hispanic or Latino____
Not Hispanic or Latino_____

Street Address:_____

City_____ State_____ Zip_____

Home Phone:(_____)_____Cell:(_____)_____

Email:_____

Marital Status (Circle): Child Single Married Separated Divorced Widowed

Primary Care Physician:_____

Emergency Contact:

Name:_____ Relation:_____

Phone Number:(_____)_____Address:_____

City:_____ State:_____ Zip Code:_____

Insurance Information:

Card Holder/Guarantor:_____
Last Name First Name M.I.

Guarantor Social Security Number:_____D.O.B:_____

Guarantor Street Address:_____

City:_____ State:_____ Zip:_____

Guarantor Phone Number:(_____)_____Gender (Circle): Male Female

Relationship to Patient (Circle): Parent Spouse Other - Explain:_____

Pharmacy:_____ **Location**:_____