



## 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: \_\_\_\_\_