PATIENT REGISTRATION FORM

Office Use Only:__________ (CSR initial)
**My initial signifies that the information on this form has been uploaded into the EMR.*

******Please write legibly so that we may enter your information accurately******

PATIENT INFORMATION

First Name:______________________________ Last Name:______________________________ Suffix:________

SSN:________-________-________ Home Phone:______________________ Cell Phone:______________________

Middle Name:____________________ Email Address:____
**Provide your email address to receive updates on your bill/statements. We promise not to send you any junk mail because we don't like those either! (Our Newsletter is informative, we swear*

Date of Birth________/________/________ Sex at Birth: ❑M ❑F ❑Other Marital Status: ❑Married ❑Single

Mailing Address:______________________________________ City/State/Zip Code:______________________

Suite/Ste/Bldg.:______________________________________

What is your preferred method of communication? ❑ Cell Phone ❑ Home Phone ❑ Email ❑ Mail

Race:________________________ Preferred Language:____________________ Hispanic/Latino: ❑ YES ❑ NO

How did you hear hear about us?
❑ Drive By ❑ Insurance ❑ Doctor (Referring Physician/Hospital:______________________________)
❑ Employer ❑ Friend/Family ❑ Hotel ❑ Internet ❑ Instagram
❑ Facebook ❑ First Aid Station/Event (Please specify):______________________________)

Preferred Pharmacy City:______________________ **Preferred Pharmacy Zip Code:**______________

PRIMARY CARE PHYSICIAN INFORMATION

Primary Care Physician:______________________________ **Phone Number:**______________________
❑ *I do not have a primary care physician* ❑ *I don't know who my primary care physician is*

EMERGENCY CONTACT/NEXT OF KIN **Please provide the BEST contact numbers for each contact*

1. Name:______________________ Relationship:____________ Phone Number:______________________
2. Name:______________________ Relationship:____________ Phone Number:______________________

PERSONAL INSURANCE COVERAGE

Primary Insurance:______________________________ Secondary Insurance:______________________________

Name of Policy Holder:__________________________ Name of Policy Holder:__________________________

Member ID Number:______________________________ Member ID Number:______________________________

Group Number:__________________________________ Group Number:__________________________________

Policy Holders SSN:______________ DOB:___/___/___ Policy Holders SSN:______________ DOB:___/___/___

Relationship to Patient:__________________________ Relationship to Patient:__________________________

GUARANTOR'S INFORMATION **Please include your information if you are checking in a patient younger than 18 years old.*

First Name:______________________________ Last Name:______________________________

Date of Birth:______________ SSN:________________ Phone Number:______________________

Address:____
Street Address *City/State/Zip Code*

I certify that the information provided is correct to the best of my knowledge. I will not hold Urgent Care Hawaii, LLC, its health providers, or its employees responsible for any errors or omissions that I may have made in completing the information on this form. I understand that URGENT CARE HAWAII may contact me with any given contact information provided on this form, this includes my Guarantor's Information and/or Emergency Contact. I understand that I may contacted by URGENT CARE HAWAII's billing company, acting on behalf of Urgent Care Hawaii, LLC regarding any financial responsibilities.

Print Name of Patient/Guardian:______________________________ **Date:**______________________

Signature of PatientGuardian:______________________________